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La clinique mobile d'enseignement est un programme de perfectionnement en éducation spéciale destiné aux enseignants du primaire et du secondaire. Dans le cadre de ce programme, un enseignant-animateur a tenu des cliniques d'une durée de trois semaines dans différentes écoles. Ces sessions avaient pour but d'améliorer les habiletés diagnostiques des enseignants, leurs méthodes d'enseignement face à des élèves souffrant de troubles légers d'apprentissage, enfin l'attitude et la confiance des enseignants face à une telle clientèle. Le volume décrit et évalue le projet.

L'implantation du programme a eu lieu en 1980-1981 sur le territoire de la commission scolaire Laurenval. Entre octobre et mai, des cliniques ont été tenues dans huit écoles. Outre l'animateur, elles réunissaient un enseignant de l'école hôtesse et trois enseignants venant d'autres écoles; de plus, dix enfants des classes régulières de l'école, souffrant de troubles légers d'apprentissage, participaient à la clinique. Un groupe témoin de dix élèves était également constitué. L'évaluation a été faite sur le mode pré-test, post-test; elle comprend des questionnaires d'opinion et d'attitudes destinés aux directeurs d'école et aux enseignants participants, de même que des tests de rendement scolaire destinés aux enfants.

Le programme a été considéré par les enseignants participant aux cliniques comme une expérience des plus positives et qui leur a permis de faire des apprentissages réels dans la façon d'aborder les élèves manifestant des troubles d'apprentissage. Par ailleurs, les enfants qui ont participé aux cliniques ne semblent pas avoir vu leur rendement affecté par cette expérience, que ce soit de façon négative ou positive. Dans l'ensemble, le programme semble se révéler une façon remarquable d'assurer le perfectionnement des enseignants.

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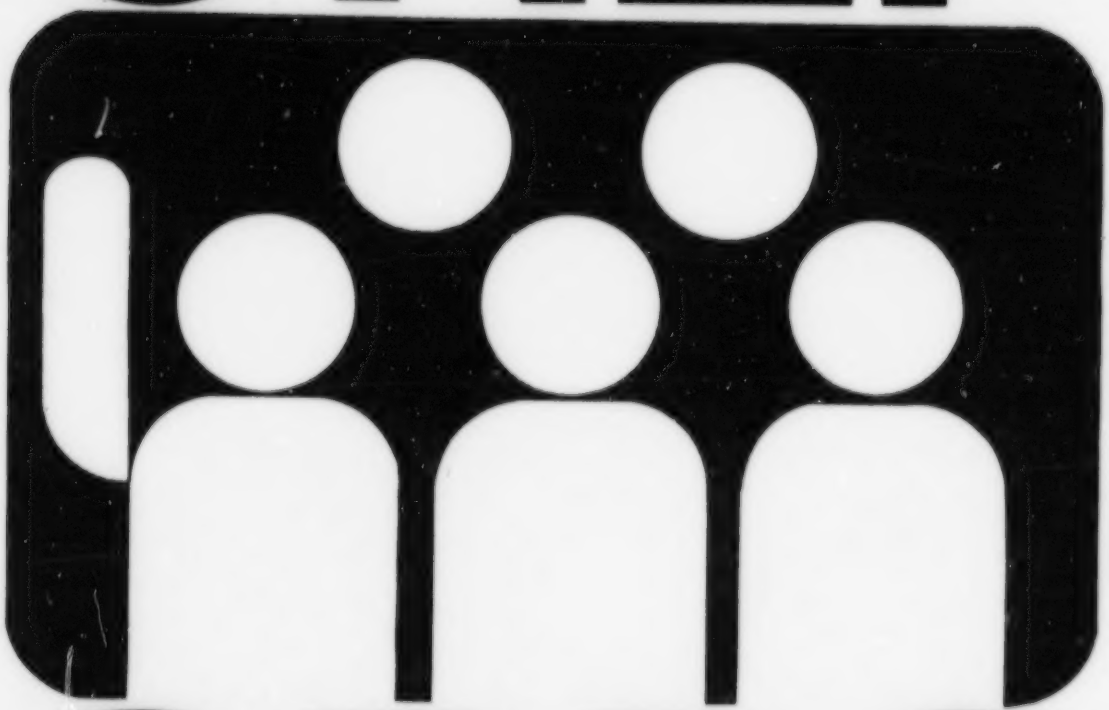

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Faculty of Education
Administration and Policy Studies

McGill University

Laurenval Mobile Clinic

Final Report

Gary J. Anderson
Jeffrey Derevensky
Janyne M. Rahming
Lois Tetreault

June 1981

McGILL UNIVERSITY, FACULTY OF EDUCATION, OFFICE OF RESEARCH ON EDUCATIONAL POLICY

LAURENVAL MOBILE CLINIC PILOT PROJECT

LAURENVAL SCHOOL BOARD

McGILL UNIVERSITY, FACULTY OF EDUCATION, OFFICE OF RESEARCH ON EDUCATIONAL POLICY

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PROJECT AND RESEARCH TEAMS

Project Personnel - Laurenval School Board

Assistant Director General	Bruce Campbell	Overall administration and supervision
Special Education Consultants	Wilma Goodman Bal Rampersad	Supervision, support, and administrative responsibility for project
Clinic Teacher	Vivian Tzipris Cole	Daily clinic activities

Research Personnel - Office of Research on Educational Policy McGill University

Director of OREP	Dr. Gary Anderson	Overall administration, supervision, and consultation
Project Director	Dr. Jeffrey Derevensky	Research supervision and consultant services
Research Associates	Janyne M. Rahming Lois Tetreault	Research design, instrumentation, analysis and report writing
Research Assistant	Sharon Crytrynbaum	Data collection
Administrative Assistant	Sylvia Sklar	Administrative duties
Secretary	Geraldine Norton	Typing and preparation of research instruments and reports

I. INTRODUCTION

The mobile learning clinic was an in-service special education program in which an animator/master teacher travelled to various schools in order to provide a three-week clinic experience session for teachers from neighbouring schools. The purpose of the clinic session was to train teachers in diagnostic and prescriptive teaching techniques, as well as to attempt to improve teacher attitudes and confidence in dealing with learning disabled children attending the regular classroom setting. The clinic session further provided additional educational services to pupils experiencing academic difficulty who were enrolled as participants in the clinic and offered the teachers of these children a clinical report designed to assist in the selection of appropriate remediation strategies. The evaluation of this model, as agreed upon with the Ministry, focussed on the effectiveness of the clinic model upon teachers and pupils as well as on the feasibility of supporting such a model from a more general administrative perspective. This evaluation was based upon the model implemented in the Laurenval School Board during the 1980-1981 academic year.

II. THE MODEL

Background Information and Scope of Project

While detailed information concerning the geographical and demographic context in which the board is located can be found in

Appendix A, it should be noted that some substantial distances exist between schools, a factor which played an important part in the selection of a mobile/travelling clinic as an appropriate method for providing in-service sessions. The Laurenval School Board includes both French and English programs of instruction and receives a substantial minority of pupils from Greek homes. These considerations also favored the adoption of an on-site community needs approach to in-service teaching. The School Board was especially concerned in providing teachers from both elementary and secondary levels, and both French and English sectors, with an opportunity to participate in the program. This became possible through the model which provided for brief intensive sessions spread over the academic year, thereby maximizing the number of participants. All schools within the School Board were, in fact, served by the project.

The Clinic Model - Participants

Figure 1 illustrates the participants in the clinic experience. The host school received the clinic animator and three participating teachers from neighbouring schools. These teachers volunteered and had been selected for participation by their home school. There were usually three sender schools per clinic. Before the beginning of the clinic, teachers of the host school were asked to recommend 20 pupils to the clinic. Teachers recommended those pupils who were experiencing minor learning difficulties, pupils who may have been generally under-achieving,

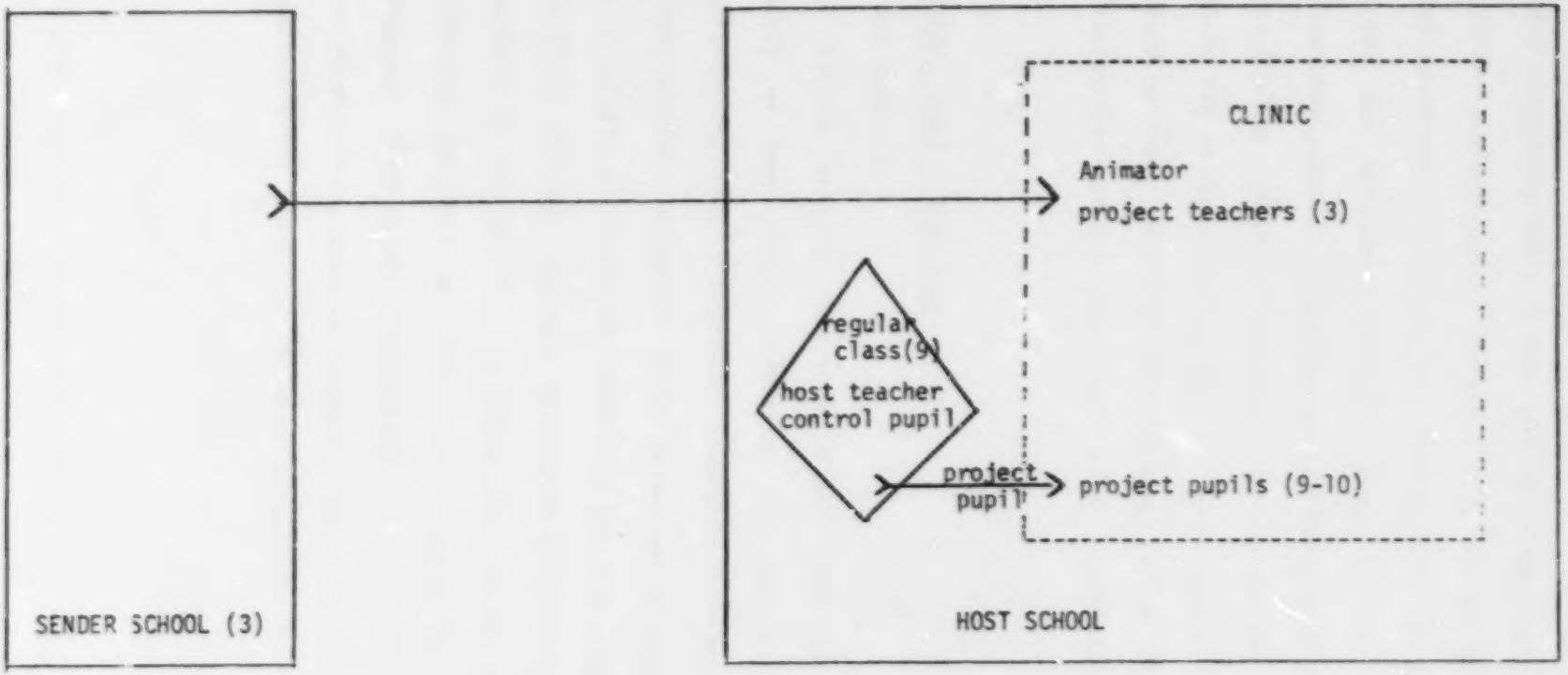


Figure I: Participation in Mobile Learning Clinic

or those exhibiting signs of poor self-confidence and motivation. The clinic excluded pupils currently enrolled in self-contained special education classes or who demonstrated signs of severe emotional and behavioral problems since it was felt these children were receiving individualized programs through specially trained special education teachers. Further details on student selection can be found in Appendix B. After random selection by the research team, 10 pupils were assigned to the clinic and 10 constituted the control group with which comparisons could be made.

The Clinic Model - Resources

Physical Resources

The project required that each of the eight schools which served as host school receiving the mobile clinic and participants, make a classroom available for the three-week clinic session. A typical clinic layout can be seen in Figure 2. A variety of educational materials was also required since the clinic sessions included activities designed to introduce teachers to new materials suitable for use in remediation activities as well as materials designed for classroom diagnosis of learning difficulties. The complete list of reading materials, remedial program, and diagnostic materials utilized in the clinic can be found in Appendix D.

BLACKBOARD - ALPHABET LINE
CLINIC AND STUDENT MATERIALS
READING - GAMES Phonic-Linguisitic
MATH - GAMES MATERIALS
Sink and water fountain
Window
entrance
Inservice - lecture - conferencing corner
Comprehension programs, film strips and cassettes, audio-visual comprehension tapes, comprehension approaches
materials
teacher
Inservice Material - movies, kits, lectures audio-visual, materials
Math - approaches, workbooks, programs materials
Movie Screen
BLACKBOARD
Perceptual-Motor approaches
shelves - perce, ual programs and materials
Project Table
Shelves - Phonic approaches and materials
Decoding materials
linguistic and phonic programs and workbooks-language master

Figure 2 - Clinic Layout

Human Resources

There were several different levels of involvement of personnel concerned with the project. The clinic teacher, who received a one-year appointment for this purpose, was responsible for directing all clinic activities as well as for planning and clinically evlaluating the different sessions.

Clinic Teacher

It should be noted that the role intended for the clinic animator required the search for a candidate fulfilling several major requirements. A clinic teacher was perceived to be a master teacher possessing skills in prescriptive and diagnostic teaching, one who possesses a familiarity with existing curriculum within the schools, a person who could provide guidance in curriculum change and implementation, has knowledge of board policies and who has a high level of interpersonal skills as a teacher trainer. It would appear that most of the skills required suggest that a psychologist who has a considerable level of classroom experience might be an ideal candidate. In addition, since the clinic service was to have included Francophone personnel and pupils, the clinic teacher required a working knowledge of French as well as educational background in the pedagogy of French. Obviously, such a candidate could not have been easy to find, especially where a variety of constraints affected the conditions under which the appointment could be made. For a further review of

some of the difficulties involved the reader is referred to Appendix C.

Special Education Consultants

The two special education consultants working within the Laurenval School Board had a significant role in all phases of the program. In addition to executing their more regular duties, these specialists were responsible for initiation and direct supervision of the clinic as well as for the numerous pertinent and necessary administrative issues related to the scheduling and organization of clinic sessions. In addition, these consultants provided the link through which research activities could be carried out. These activities often required about twenty per cent of their consultation time.

Subject Area Consultants

A number of other within-board personnel were regularly involved in the clinic, primarily as resource persons providing in-service sessions for clinic participants. Among these, the most regularly involved were free flow teachers, the math consultant, a special education teacher, psychologists, guidance counsellors, and speech therapists. In-service topics included the following:

Learning Characteristics of Exceptional Children
Diagnostic/Prescriptive Teaching Programme
Problems/Academic Patterns of the Learning Disabled Child
Test Interpretation
Classroom Organization/Behavior Management Techniques
Major Approaches/Remedial Techniques in Reading, Math, Spelling, Writing, and Perceptual Motor Functioning
English as a Second Language
Language Development
Multi Disciplinary Team Approach
Self Concept, Personality and Emotional Disorders
Report Writing

The Clinic Model - Activities and Schedules

Scheduling

a) clinic sessions

Figure 3 provides a schedule of the clinic sessions which were held during the 1980-1981 school year.

HOST SCHOOLS

		VISITING TEACHERS
Oct 9 - Oct 31	Elmwood	Rawdon McCaig Lewis King
Nov 5 - Nov 25	Lake of Two Mountains	Joliette High School Lake of Two Mountains High School Western Laval High School Rosemere High School
Dec 1 - Dec 19	Souvenir	Hillcrest Bowes/Prince Charles Gordon
Jan 7 - Jan 28	Twin Oaks	Chomedy High School Crestview Souvenir
Feb 4 - Feb 25	Crestview	Pierre Laporte Twin Oaks Irving Bregman Memorial
Mar 4 - Mar 25	McCaig	Elmwood Mountainview Village des Jeunes
Apr 1 - Apr 24	Rawdon Elementary	Joliette Elementary Joliette High School
May 4 - May 22	Chomedy High School	Lake of Two Mountains Rosemere High School Western Laval High School

Figure 3 - Schedule of Clinic Sessions

b) Schedule of activities within a typical clinic session

Pre-Clinic Activities:

The clinic teacher was primarily responsible for these activities, although the special education consultants had an integral supportive and administrative role. These activities occurred during the 3-4 days prior to each clinic and included the following:

research for available clinic materials, programs, remedial techniques in all areas of learning disabilities, tapes and educational media available at Curriculum Centre.

organization of above material into categories of reading, arithmetic, perceptual-motor writing, spelling, fine motor, for example.

research into tests available at Curriculum Centre.

conferences with Language Arts and Math specialists about programs taught and used in the Laurenval School Board and within each school.

developing and mailing letters to students, teachers and parents requesting release of testing and academic data.

discussions with psychologist about clinic children.

consultations with principals and the clinic children's classroom teachers to ascertain pertinent information.

visiting schools where clinic would be taking place.

arranging room for clinic and transferring clinic material to room.

studying and analyzing student files and test data, organizing information, constructing a student referral sheet to be given to students' teachers to complete.

regular meetings with special education consultants to discuss clinic rotations, schedules, in-service topics, follow-up days, nature and schedule of clinic, evaluations of clinic and reports on children, planning schedule of the children on a

daily basis.

assigning students to two groups, and planning students' daily schedules depending on severity of difficulty.

planning daily remedial needs for the entire clinic scheduling all students on a daily basis.

research and preparation of in-service information to be given to teachers.

visits to regular and special education programs in Laurenval schools.

meetings with free flow remedial teachers concerning clinic pupils and in-service workshops

media orientation sessions

putting materials together - preparing students' schedules for entire clinic session.

writing information; letters regarding the clinic to parents and teachers.

speaking to classroom teachers and free flow teachers.

examining teachers referral forms concerning clinic children and ascertaining pertinent data.

Clinic Schedule for Participants:

The following is a sample of daily activities in each clinic:

Day 1

Orientation session for teachers to discuss the purpose and objectives of the three week clinic plan.

Teachers examine student information concerning:
- files for clinic use
- referral sheet from classroom teacher

Examine diagnostic materials available

Prepare introductory activities for students.

Meet all clinic students.

Set up the clinic room.

Match teachers to students; final scheduling of students.

Observation of activities with students and discussion.

Day 2-13

9:05 - 9:30	- Preparation and planning days activities
9:30 - 10:40	- Students/Group 1
10:40 - 11:00	-----Break-----
11:00 - 11:30	- Students/Group 2
11:30 - 12:30	- In-Service - Teachers
12:30 - 1:30	-----Lunch-----
1:30 - 2:20	- Students/Group 3
2:20 - 3:00	- Conferencing/Lesson Plans

Day 14

9:05 - 11:00	- same as Day 2
11:00 - 12:30	- use in-service period for strategies and format for report writing
1:30 - 3:00	- Report writing and feedback to school personnel

Day 15

- In-service
- Report writing and feedback to school personnel
- Overall clinic evaluation
- Assistance in packing materials and cleaning room

Additional clinic session activities:

These occured outside clinic hours but during the session and were the responsibility of the clinic teacher.

periodic meetings with special education consultants concerning schedules, revising in-service programs, reporting to parents and teachers, preparation of materials.

xerox and preparation of clinic materials.

planning meetings with visiting speakers.

review of programs and materials.

III. RESEARCH ACTIVITIES

Design

Due to time and financial constraints four elementary school clinics were selected for inclusion in the research design. Figure 4 illustrates the design and data collection procedures of the research program. The questionnaires used in this study were developed or adapted by OREP (McGill University) for this project. Copies of these questionnaires can be found in Appendix E. All clinics included in the evaluation study were held in English-speaking elementary schools, however, some teachers were

presently teaching in Secondary Schools (Cycle 1).

Ethical Concerns and Communication

All teachers volunteered for participation in the project and were informed of the nature both of clinic activities and of research procedures. The parents of pupils recommended for the clinic were also informed of the nature of activities and provided their consent for the child's participation. Parents received a clinic report which outlined the nature of the child's difficulties and provided suggestions as to home activities which could be helpful for the child. The regular classroom teachers of the clinic children also received a special clinic report.

An ethical research statement was also submitted to the McGill University Research Committee within the Faculty of Education for approval which was granted. Copies of these documents can be found in Appendix F.

III. RESEARCH ACTIVITIES

Design

A sample of five clinics were selected for the research. Figure 4 illustrates the design and data collection procedures of the research. The questionnaires used in this study were developed or adapted by OREP for this project. Copies of these questionnaires can be found in Appendix D.

	PRINCIPALS	PROJECT TEACHERS	HOST TEACHERS	STUDENTS	
				EXPERIMENTAL	CONTROL
PRE CLINIC TESTS	Opinion Survey	Knowledge 1. Exceptional Children 2. Diagnostic Teaching Opinions 1. Application 2. Attitudes	Behavior Rating Scale (1 Clinic & 5 other children from class)	Stanford Diagnostic Reading Stanford Diagnostic Mathematics Self Concept Scale Clinic Administered Tests	Stanford Diagnostic Reading Stanford Diagnostic Mathematics
IMMEDIATE POST CLINIC TESTS		Knowledge 1. Exceptional Children 2. Diagnostic Teaching Perceptions of Program-General		Clinic Administered	
DELAYED POST CLINIC TESTS	Perceptions of Program - Questionnaire	Perceptions of Program - Questionnaire		Stanford Diagnostic Reading Stanford Diagnostic Mathematics Behavior Rating Scale	Stanford Diagnostic Reading Stanford Diagnostic Mathematics Behavior Rating Scale

Fig. 4 MOBILE CLINIC PROJECT RESEARCH DESIGN

Selection Procedures

It should be noted that project teachers were selected from a pool of volunteers by their school and the selection of these teachers was not controlled by the research. Throughout this report, these teachers are referred to as "project teachers". Teachers in the host school are referred to as "host teachers". While pupils were recommended by teachers in the host school, the research design provided for a control group of students who did not attend the clinic. Recommended students were randomly assigned to either a clinic or control group by the researchers.

Research Instruments and Data Collection Procedures

Principals:

Principals who sent a project teacher to a clinic are referred to as "sender principals", while those who hosted a clinic in their schools are referred to as "host principals". Principals of all the involved schools were asked at the pre-test stage to complete an opinion survey. In the original research design, it was planned that principals would again respond to the opinion survey and a general questionnaire dealing with their global perceptions of the clinic during the delayed post-test period of April and May, 1981. Due to difficulties in obtaining the co-operation of participants, this aspect was eliminated. Rather, principals were asked to respond to an open-ended questionnaire dealing with what they liked most and least about their involvement with the clinic. It should be pointed out at this stage that this

involvement ranged from that of a "Host" principal to that of a principal of a "Sender" school.

Project teachers:

At the pre-test stage, project teachers completed a questionnaire designed to tap both their knowledge of and attitudes toward exceptional children. In the immediate post-test period, two parts of the questionnaire were repeated. In addition, teachers also completed a questionnaire on their perceptions of the clinic program. In the original research design, it was planned that all measures would be repeated during the delayed post-test period. Due to difficulties in obtaining the co-operation of those concerned, this aspect was eliminated. Rather, they were asked to respond to a brief questionnaire.

Pupils:

While it was impossible to measure the direct effect of the clinic experience on pupils academic progress since it was only a three week intervention, the research hoped to establish that pupils involved in the clinic experience compared favourably, or at the very least, did as well as, control students who had been retained in their regular classes. Measures included for both experimental and control groups covered the areas of reading and mathematics achievement as well as self-concept and behavior ratings by their teachers. In addition, pupils involved in the clinic underwent diagnostic testing as a formal part of the

clinic experience.

Host Teachers:

Host teachers were asked to complete a behaviour rating scale for each pupil attending the clinic, as well as five other children from their class. In the original design it was planned that they would provide their perceptions of the clinic program in terms of the feedback they had received from the clinic, and its usefulness to them. Since "Host" teachers did not receive this information during the expected time period, this aspect of the design had to be eliminated. Due to difficulties in obtaining the necessary co-operation of participants the delayed post-clinic data collection originally planned was also eliminated.

IV. TREATMENT OF DATA

The data analysis was intended to examine the effects of the mobile clinic upon student achievement and the acquisition of diagnostic, prescriptive and remedial techniques by the participating teachers. More specifically, it sought to determine whether or not changes in academic performance for students participating in the three week mobile clinic increased, decreased, or remained constant and to test the feasibility of the mobile clinic as an in-service methodology in preparing teachers to work with children experiencing minor learning and

behavioral problems within the regular classroom. As a result the data are presented in three parts: Part A - Student Data; Part B - Teacher Data; and Part C - Reports from Administrators, Consultants, and Teaching Staff at Host Schools. It is important to note at the outset that the data only represent the evaluation of four clinics and thus the teacher data represent a total number of 12 participating teachers.

A. Student Achievement Data

The data in Table 1 provide a descriptive analysis of the students involved in the program. Wherever possible, an equal number of control students was obtained from the original list of those students recommended for participation within the clinic. The research data represent a total number of 41 students participating within the clinic and a matched group of 36 control students. The discrepancy between the size of the two groups reflects subject loss in the control group.

One very important question that was asked within the present evaluation was whether or not academic performance of those students participating in the three week clinic, and thus leaving their home classroom for this period of the time, would suffer a substantial loss because of lack of continuity of the curriculum. As can be seen from Table 2 and Table 3, little difference was found on a post-clinic comparison of those students participating

in the clinic with those participating in the control group. This is true for all sub-tests on the Stanford Diagnostic Reading and Stanford Diagnostic Mathematics Tests.

TABLE 1

LAURENVAL STUDENTS MOBILE CLINIC PROJECT
DESCRIPTIVE STATISTICS

		MALE	FEMALE
CLINIC STUDENTS		24	17
CONTROL STUDENTS		25	11
GRADE LEVELS:	GRADE 1		11
	2		12
	3		14
	4		16
	5		21
	6		3
			77

STUDENTS BY CLINIC:	CLINIC	CONTROL	TOTAL
SOUVENIR	11	7	18
TWIN OAKS	10	9	19
CRESTVIEW	10	10	20
McCAIG	10	10	20
			77

TABLE 2

T-TEST

POST-CLINIC COMPARISONS OF ALL CLINIC AND CONTROL STUDENTS ON ACHIEVEMENT MEASURES

TEST	CLINIC		CONTROL				
STANFORD DIAGNOSTIC READING	X	SD	X	SD	df	t	p
RED LEVEL	(N=17)		(N=11)				
Auditory Vocabulary	32.82	9.13	32.0	6.38	26	.26	
Auditory Discrimination	31.35	5.73	32.72	3.00	26	- .73	
Phonetic Analysis	36.35	2.99	37.54	1.57	26	-1.21	
Word Reading	38.70	4.60	39.36	3.04	26	- .42	
Reading Comprehension	39.35	8.17	43.00	3.57	26	-1.39	
Total Comprehension	78.05	12.11	82.36	6.13	26	-1.09	
GREEN LEVEL	(N=15)		(N=15)				
Auditory Vocabulary	31.66	5.34	30.00	4.75	28	.90	
Auditory Discrimination	30.80	4.75	31.86	4.51	28	- .51	
Phonetic Analysis	24.66	6.44	25.40	7.26	28	- .29	
Structural Analysis	46.86	13.73	51.33	7.59	28	-1.10	
Total Comprehension	42.60	12.63	40.4	13.89	28	.45	
STANFORD DIAGNOSTIC MATHEMATICS							
RED LEVEL	(N=14)						
Number System	20.42	5.51	23.12	5.08	20	-1.13	
Computation	22.42	8.13	27.62	4.13	20	-1.68	
Application	19.35	6.38	20.00	5.95	20	- .23	
Total Math	48.38	31.28	51.45	34.8	27	- .25	
GREEN LEVEL	(N=15)						
Number System	22.33	8.31	20.76	7.13	30	.57	
Computation	29.80	11.571	33.58	8.85	30	-1.05	
Application	11.60	7.38	11.70	6.95	30	- .04	
Total Math	63.73	24.35	62.38	25.28	31	.15	

* $p < .05$
** $p < .01$
*** $p < .001$

TABLE 3

T-TEST

POST-CLINIC COMPARISONS OF ALL CLINIC AND CONTROL STUDENTS ON ACHIEVEMENT MEASURES

TEST	CLINIC		CONTROL	
STANFORD DIAGNOSTIC READING	AVERAGE RAW SCORE	AVERAGE GRADE EQUIVALENT	AVERAGE RAW SCORE	AVERAGE GRADE EQUIVALENT
RED LEVEL (N=17)			(N=11)	
Auditory Vocabulary	32.8	2.6	32.0	2.6
Auditory Discrimination	31.3	1.8	32.7	1.9
Phonetic Analysis	36.3	2.3	37.5	2.4
Word Reading	38.7	2.6	39.4	2.8
Reading Comprehension	39.3	2.4	43.0	2.8
Total Comprehension	78.0	2.3	82.4	2.4
GREEN LEVEL (N=15)			(N=15)	
Auditory Vocabulary	31.7	4.2	30.0	4.1
Auditory Discrimination	30.8	2.8	31.9	3.3
Phonetic Analysis	24.7	4.1	25.4	4.4
Structural Analysis	46.9	3.7	51.3	4.5
Total Comprehension	42.6	3.3	40.4	3.2
STANFORD DIAGNOSTIC MATHEMATICS				
RED LEVEL (N=14)				
Number System	20.4	2.5	23.1	2.8
Computation	22.4	2.5	27.6	3.0
Application	19.3	2.4	20.0	2.5
Total Math	48.4	2.1	51.4	2.2
GREEN LEVEL (N=15)				
Number System	22.3	4.2	20.8	3.9
Computation	29.8	4.2	33.6	4.5
Application	11.6	3.3	11.7	3.3
Total Math	63.7	4.1	62.4	4.1

An examination of the data presented in Table 4 indicates that students attending the clinic seem to make significant improvement in a variety of sub-tests on the Stanford Diagnostic Reading Test. This is most notable in the area of vocabulary development. However, little gain is made in mathematical development. Table 5 indicates changes in the grade equivalence scores and one can see within this table a general improvement across many of the sub-tests within the Stanford Diagnostic Reading Test as well as the Stanford Diagnostic Mathematics sub-tests. It is important to note that the standard error of measurement on the Stanford Diagnostic Reading and the Stanford Diagnostic Mathematics Test is large enough in conjunction with a small number of pupils to preclude statistically significant differences from occurring over a relatively short period of time. However, it appears that educationally meaningful gains have been made in many of the areas within the reading and mathematics sub-tests. It is also important to note that the analysis is conducted on data collected within a relatively short time lapse between pre-test and post-test, with a maximum of five months and a minimum of three weeks between the two. Thus, true academic gains may be masked and may only be realized after a much longer post clinic evaluation.

TABLE 4

T-TEST

PRE AND POST CLINIC COMPARISONS OF CLINIC STUDENTS
ON ALL ACHIEVEMENT MEASURES

TEST	PRE-CLINIC X	PRE-CLINIC SD	POST-CLINIC X	POST-CLINIC SD	df	t	p
STANFORD DIAGNOSTIC READING							
RED LEVEL (N=17)							
Auditory Vocabulary	24.41	5.13	32.82	9.13	16	-4.20	.001***
Auditory Discrimination	31.35	5.71	31.35	5.73	16	0	
Phonetic Analysis	35.47	5.44	36.35	2.99	16	- .92	
Word Reading	34.23	9.45	38.70	4.60	16	-2.35	.032*
Reading Comprehension	37.29	9.94	39.35	8.17	16	-1.14	
Total Comprehension	71.52	17.81	78.05	12.11	16	-2.31	.035*
GREEN LEVEL (N=15)							
Auditory Vocabulary	29.13	5.43	31.66	5.34	14	-2.16	.048*
Auditory Discrimination	31.33	5.23	30.80	6.72	14	.38	
Phonetic Analysis	22.00	7.39	24.66	6.44	14	-2.17	.048*
Structural Analysis	46.46	10.48	46.86	13.73	14	- .16	
Total Comprehension	42.73	9.48	42.60	12.63	14	.05	
STANFORD DIAGNOSTIC MATHEMATICS							
RED LEVEL (N=14)							
Number System	18.50	7.28	20.42	5.51	13	-1.54	
Computation	21.21	8.67	22.42	8.13	13	-1.00	
Application	18.53	6.80	19.15	6.59	13	- .58	
Total Math	53.85	26.54	62.21	18.79	13	-1.45	
GREEN LEVEL (N=15)							
Number System	22.53	5.74	22.33	8.31	14	.14	
Computation	29.33	11.83	29.80	11.57	14	.18	
Application	10.60	6.31	11.60	7.38	14	- .75	
Total Math	60.47	25.87	59.70	27.51	14	.11	

* $p < .05$
** $p < .01$
*** $p < .001$

TABLE 5

T-TEST

PRE AND POST CLINIC COMPARISONS OF CLINIC STUDENTS
ON ALL ACHIEVEMENT MEASURES

TEST	PRE-CLINIC		POST-CLINIC	
STANFORD DIAGNOSTIC READING	AVERAGE RAW SCORE	AVERAGE GRADE EQUIVALENT	AVERAGE RAW SCORE	AVERAGE GRADE EQUIVALENT
RED LEVEL (N=17)				
Auditory Vocabulary	24.4	2.0	32.8	2.6
Auditory Discrimination	31.3	1.8	31.3	1.8
Phonetic Analysis	35.5	2.1	36.3	2.3
Word Reading	34.2	2.3	38 7	2.6
Reading Comprehension	37.2	2.3	39.3	2.4
Total Comprehension	71.0	2.2	78.0	2.3
GREEN LEVEL (N=15)				
Auditory Vocabulary	29.1	3.9	31.7	4.2
Auditory Discrimination	31.3	3.3	30.8	2.8
Phonetic Analysis	22.0	3.6	24.7	4.1
Structural Analysis	46.5	3.7	46.9	3.7
Total Comprehension	42.7	3.3	42.6	3.1
STANFORD DIAGNOSTIC MATHEMATICS				
RED LEVEL (N=14)				
Number System	18.5	2.4	20.4	2.5
Computation	21.2	2.5	22.4	2.5
Application	18.5	2.2	19.1	2.4
Total Math	53.8	2.2	62.2	2.5
GREEN LEVEL (N=15)				
Number System	22.5	4.2	22.3	4.2
Computation	29.3	4.2	29.8	4.2
Application	10.6	3.1	11.6	3.3
Total Math	60.5	4.0	59.7	3.9

The results seem to indicate that student achievement based upon the Stanford Diagnostic Reading and Diagnostic Mathematics is increasing for those pupils attending the clinic and that no detrimental loss of academic achievement is apparent.

The data also sought to determine whether or not teachers perceived a behavioral change in students attending the clinic. These data, presented in Table 6, are based upon behavioral measures and while no statistically significant differences are apparent the time span between initial testing and post-clinic comparisons may have again significantly affected these results. It is important to note that no significant behavioral problems were reported by teachers for those pupils attending the small intimate clinic which had a low adult-child ratio.

In terms of the child's perception of himself a modified Piers-Harris Self Concept Scale was employed and some changes are noted in Table 7. There appears in general to be a small decrement on most of the five sub-scales and total self concept score on the modified Piers-Harris test. One possible explanation for this is that after having received individualized instruction in the mobile clinic the child returned to the regular classroom setting. Individualized attention was no

TABLE 6

T-TESTS

PRE AND POST CLINIC COMPARISONS OF CLINIC STUDENTS ON BEHAVIORAL MEASURES.

CLASSROOM BEHAVIOR INVENTORY (N=40)

	PRE-CLINIC		POST CLINIC				
	X	SD	X	SD	df	t	p
1. EXTROVERSION	8.02	2.33	8.27	2.136	39	-.88	
2. TASK ORIENTATION	7.00	2.801	7.55	2.67	39	-1.49	
3. INTROVERSION	7.17	3.02	7.55	2.28	39	-.94	
4. DISTRACTABILITY	9.62	2.25	9.12	2.61	39	1.71	
5. HOSTILITY	5.82	2.57	5.90	2.29	39	-.24	
6. CONSIDERATION	8.75	2.46	9.15	1.92	39	-1.39	
7. ADJUSTMENT	2.34	.87	2.42	.75	37	.65	
8. PEER RELATIONSHIPS	3.60	1.15	3.39	1.07	37	1.48	

* $p < .05$
** $p < .01$
*** $p < .001$

TABLE 7

T-TEST

PRE AND POST CLINIC COMPARISONS OF CLINIC STUDENTS
ON A MODIFIED PIERS-HARRIS
SELF CONCEPT TEST

SELF CONCEPT INVENTORY (N=37)

	PRE-CLINIC		POST CLINIC				
	X	SD	X	SD	df	t	p
1. BEHAVIOR	7.27	2.28	6.81	1.71	36	1.10	
2. SCHOOL STATUS	9.32	2.18	8.72	1.99	36	1.55	
3. ANXIETY	3.59	2.29	3.24	2.37	36	.88	
4. POPULARITY	3.51	1.59	2.86	1.78	36	2.90	.01**
5. HAPPINESS	10.05	2.26	9.67	2.02	36	1.02	
6. SELF CONCEPT TOTAL	33.75	7.95	31.32	6.12	36	1.93	

* $p < .05$
** $p < .01$
*** $p < .001$

longer available in a large classroom and consequently may have had a negative effect upon the child's self concept. However, while the popularity subscale seems to be significantly different the question still remains as to whether or not this is educationally meaningful. A decrement of .65 from a mean of 3.51 to 2.86 does not appear to be clinically meaningful in terms of the student's perception of himself. As well, to reiterate, no Host Teacher indicated any significant emotional or behavioral changes after the child returned to the regular classroom setting.

B. Teacher Evaluation

The descriptive data presented in Table 8 are based upon the 12 teachers participating in the research design component of the Mobile Clinic. There are many more female teachers than male teachers from the elementary school population, and the average age distribution appears to be quite normal. Most teachers tended to have between 6 and 15 years of experience with 3 teachers having between 26 and 35 years experience. The small numbers precluded any further breakdown by scholarity, teaching experience, and age.

The major comparison in terms of pre and post-clinic intervention was based upon a questionnaire which sought to determine the knowledge of exceptional children in general, as well as

TABLE 8

LAURENVAL CLINIC TEACHERS

DESCRIPTIVE DATA

TOTAL TEACHERS WHO PARTICIPATED IN ALL CLINICS - 23

TOTAL TEACHERS INCLUDED IN RESEARCH DESIGN - 12

SEX	FEMALE	- 10
	MALE	- 2
AGE RANGE	20-30 years of age	- 3
	31-40	- 5
	41-50	- 3
	51-60	- 1
DEGREES HELD	BA	- 4
	BED	- 5
	BSC	- 2
	MA	- 1
SPECIALIST DIPLOMAS HELD IN	SPECIAL EDUCATION	- 1
	READING	- 1
	PHYS ED	- 1
	NONE	- 9
NUMBER OF YEARS TEACHING	6-10	- 3
	11-15	- 6
	16-20	- 1
	26-30	- 1
	31-35	- 1
CURRENT TEACHING LEVEL	1-3	- 5
	4-6	- 6
	SECONDARY I	- 1

CURRENTLY ENROLLED IN SPECIAL EDUCATION DIPLOMA PROGRAM

YES	- 3
NO	- 4
NO ANSWER	- 5

knowledge of diagnostic, prescriptive, remedial techniques, and materials in particular. This questionnaire (Appendix E) sought to determine the amount of knowledge teachers possessed before entering the clinic and upon completing the clinic. As can be seen in Table 9, while no significant difference was found in terms of their knowledge of exceptional children in general, a significant change in terms of a gain of knowledge of diagnostic techniques, clinic programs and materials was ascertained. Thus, this table clearly suggests that in terms of specific aspects of assessment strategies and remedial techniques a significant change in knowledge base has been realized. It should be noted that many of the questions within the general knowledge dealt with very specific types of disabilities which would often not be found in the regular classroom and it is not surprising that more gain should have been registered in areas which were covered specifically in the clinic.

This gain of knowledge and its implementation in a practicum setting was the goal of the program. While no statistical data are available to indicate whether this gain in insight and acquired knowledge will be directly transferred to the classroom, discussions with clinic teachers and additional questionnaire data suggest its implementation is highly likely. The data presented in Tables 10 and 11 clearly indicate the teachers' perceptions of the Mobile Learning Clinic as a very positive, valuable, worthwhile experience. They rated the information that

TABLE 9

T-TESTS

COMPARISON OF PRE AND POST CLINIC QUESTIONNAIRES
OF CLINIC TEACHERS

	PRE-CLINIC		POST-CLINIC				
	X	SD	X	SD	df	t	p
GENERAL KNOWLEDGE OF EXCEPTIONAL CHILDREN (35 Questions)	21.36	2.87	22.81	2.08	10	-1.87	
KNOWLEDGE OF CLINIC PROGRAM AND MATERIALS (25 Questions)	12.33	3.65	17.91	3.77	11	-5.29	.001 ***

* $p < .05$
** $p < .01$
*** $p < .001$

Table 10

Delayed Post-Clinic Perceptions of Clinic Teachers

MOST VALUABLE ASPECTS OF CLINIC

	Rank Order
Materials	1
Diagnostic Information	2
In-Service Aspects	3
Interprofessional Relationships	4
Methods	5
Small Group Work	6
Awareness & Understanding	7
Behavior Modification Techniques	8
Self Confidence	9

LEAST VALUABLE ASPECTS OF CLINIC

Writing of Reports	1
Lack of Follow-up of Children	2
Research Aspects	3
Time Too Short	4
Away From Home Class	5
Space and Scheduling	6
Personality Conflicts	7
Information Overload	8

Table 11

Perceptions of the Mobile Learning Clinic
by Participating Teachers

	Strongly Disagree	Disagree	Agree	Strongly Agree	Mean
	1	2	3	4	
1. Having the Clinic in this school was a worthwhile experience.	1	2	3	4	3.3
2. Discussions between the Clinic personnel and the Host School personnel were very helpful in understanding the child and his/her problems.	1	2	3	4	3.3
3. The Host Teachers will be able to benefit from the information given to them in the Clinic report.	1	2	3	4	3.1
4. Special Education teachers had sufficient opportunity to interact with the Clinic personnel.	1	2	3	4	2.5
5. Clinic personnel were available when you wanted to talk to them.	1	2	3	4	3.7
6. Parents were pleased with the Clinic experience for their child.	1	2	3	4	3.2
7. Host Teachers had sufficient opportunity to interact with the Clinic Teachers.	1	2	3	4	2.9
8. The Clinic hours were too long.	1	2	3	4	1.8
9. Host Teachers were pleased with the Clinic experience for the child.	1	2	3	4	3.1
10. There was sufficient opportunity for interaction between the Clinic Teacher and the parents.	1	2	3	4	1.8

	Strongly Disagree	Disagree	Agree	Strongly Agree	Mean
	1	2	3	4	
11. The Clinic should be in the Host School for longer than three weeks.					
	1	2	3	4	2.5
12. Reports from the Clinic were easy to understand.					
	1	2	3	4	3.0
13. The Clinic emphasized reading as much as it should.					
	1	2	3	4	3.4
14. Interactions between the Host Teachers and the Clinic Teachers were positive.					
	1	2	3	4	2.9
15. The Clinic emphasized mathematics as much as it should.					
	1	2	3	4	3.1
16. The Clinic met the needs of the children who attended.					
	1	2	3	4	3.2
17. There was sufficient opportunity for interaction between the Clinic Teacher and the Host Teachers.					
	1	2	3	4	2.7
18. The Clinic was a good experience for the teachers who participated.					
	1	2	3	4	3.5
19. Host Teachers have been able to implement the recommendations of the Clinic in their classrooms.					
	1	2	3	4	3.0
20. Host Teachers have received some very useful, practical advice about the child.					
	1	2	3	4	3.1
21. There was adequate time to fulfill all the goals of the Clinic.					
	1	2	3	4	2.0

	Strongly Disagree	Disagree	Agree	Strongly Agree	Mean
	1	2	3	4	
22. The Clinic program emphasized social/behavioral aspects as much as it should.	1	2	3	4	2.5
23. The benefits of the Mobile Clinic far outweigh any difficulties of implementation.	1	2	3	4	3.1
24. The school board should offer the Mobile Clinic program again next year.	1	2	3	4	3.4
25. Students who attended the Clinic had problems similar to those of children in the regular classroom.	1	2	3	4	3.5
26. I received support from my school for my participation in the Mobile Clinic Project.	1	2	3	4	3.0
27. Other teachers in the Clinic shared many of my concerns.	1	2	3	4	3.0
28. I received adequate information about the Mobile Clinic Project before leaving my class.	1	2	3	4	3.0
29. The substitute teacher who took over my class was adequately prepared to do so.	1	2	3	4	3.1
30. I had sufficient time to brief the substitute teacher about the children's work.	1	2	3	4	2.8
31. It was easy to prepare the children for my absence.	1	2	3	4	2.6

	Strongly Disagree	Disagree	Agree	Strongly Agree	Mean
	1	2	3	4	

22. The Clinic program emphasized social/behavioral aspects as much as it should.

1 2 3 4 2.5

23. The benefits of the Mobile Clinic far outweigh any difficulties of implementation.

1 2 3 4 3.1

24. The school board should offer the Mobile Clinic program again next year.

1 2 3 4 3.4

25. Students who attended the Clinic had problems similar to those of children in the regular classroom.

1 2 3 4 3.5

26. I received support from my school for my participation in the Mobile Clinic Project.

1 2 3 4 3.0

27. Other teachers in the Clinic shared many of my concerns.

1 2 3 4 3.0

28. I received adequate information about the Mobile Clinic Project before leaving my class.

1 2 3 4 3.0

29. The substitute teacher who took over my class was adequately prepared to do so.

1 2 3 4 3.1

30. I had sufficient time to brief the substitute teacher about the children's work.

1 2 3 4 2.8

31. It was easy to prepare the children for my absence.

1 2 3 4 2.6

	Strongly Disagree	Disagree	Agree	Strongly Agree	Mean
	1	2	3	4	

32. The children had not been negatively affected by my absence.

1	2	3	4	2.6

33. The children's work did not suffer as a result of my absence.

1	2	3	4	2.4

34. Parents did not object to having a substitute teacher in my class for three weeks.

1	2	3	4	3.2

35. Clinic participation was not overly demanding.

1	2	3	4	2.9

36. What I have learned is applicable to my own class teaching.

1	2	3	4	2.8

37. Parents supported my absence for the three week period.

1	2	3	4	3.0

they learned concerning materials and programs, the diagnostic prescriptive information, and the in-service components of the clinic most highly. Furthermore, teachers perceive the students who attended the clinic as very similar to children found in the regular classroom. While numerous teachers voiced concerns about several aspects of the program, they were in general agreement that the benefits of the Mobile Clinic far outweighed any of the implementation difficulties and strongly suggested that the clinic program should continue within the School Board. Still further, analysis of both Tables 10 and 11 clearly suggests that the techniques and methodologies presented to them by the clinic animator and the practical in-service workshops were highly regarded, and relevant, Clinic teachers also reported a willingness to initiate them in the regular classroom.

Still further, few negative results were reported concerning the academic progress in the clinic teachers' home classroom during their three week absence. This is an essential point to note, since many fears concerning this possibility were initially expressed.

Administrator's Perception of the Mobile Clinic

Since the degree of participation of school administrators within the Host Schools varied it is difficult to establish a global administative perspective. However, the following positive comments appeared frequently in administrators' evaluation

sheets:

1. Those teachers involved in the clinic became more aware of student needs and more effective teachers.
2. Clinic teachers provided valuable feedback to regular classroom teachers in the Host School.
3. Host Teachers as well as Clinic Teachers were exposed to alternative teaching methods and materials.
4. Parents of children who attended clinics were very pleased.
5. The availability of Host School Staff to participate in clinic in-services program was beneficial.

Thus, while the administrative problems associated with Clinic participation were often time-consuming and demanding for administrators, the attitude and opinion surveys of school administrators of Host and Sending schools appear to suggest that they were strongly supportive of the clinic as a favorable method of in-service training for staff. In addition the benefits derived from sharing clinic information with other teachers within the school were viewed very positively.

V. DISCUSSION AND INTERPRETATION OF RESULTS

The results of the data anlysis reported in Section IV clearly support the positive effectiveness of the first year implementation project of the Mobile Clinic. Teacher data strongly indicate both a positive approach toward the clinic, and a general acquisition of knowledge of diagnostic instruments, methods and intervention programs associated with children who are experiencing learning and behavioral problems. These children were viewed as representative of children in the regular

classroom. Programs and intervention methodologies employed in the Mobile Clinic were refreshingly new to many of the teachers as well as educationally viable. While teachers attending the Mobile Clinic identified some disadvantages (notably that of being absent from their regular classroom for the three week period of time), these were not perceived as significant enough to preclude recommendation of the clinic to their colleagues.

Student academic performance clearly indicated no decrement, and few if any adjustment problems when pupils returned to the regular class. The full-term effectiveness in terms of the educational outcomes escaped measurement as greater time may have been required before these could be realized and appropriately measured.

From an administrative point of view, principals found teachers who attended the clinics to be most helpful in transmitting information back to the home-room teacher concerning pupil progress, diagnostic features and successful intervention programs that had been implemented with the children. Teachers clearly reported that the clinic met their needs as well as those of the attending children. Reports from Administrators are also highly supportive of the clinic intervention program for teacher gains as well as for the positive experiences acquired by attending students.

Thus most teachers and students viewed the clinic experience as positive and very informative in terms of acquisition of knowledge concerning diagnostic procedures, evaluation and remedial strategies, and useful behavioral and management techniques. Teachers found the introduction of new materials and programs particularly useful, interesting, and easily applicable to the regular classroom setting. Teachers found the journals and reading material useful and found ideas in the form of clinic handouts extremely helpful and relevant. The clinic experience also enabled clinic teachers to more actively participate in the ordering of remedial materials for their home school. Several clinic teachers, after their return, conducted in-service workshop sessions in their home school concerning materials and methodologies for working with children with learning and behavioral problems. There is also evidence that many teachers became more comfortable with and had a better understanding of diagnostic and psycho-educational reports provided by the school psychologist and guidance counsellor as a result of the clinic experience.

An essential part of the program also appeared to be the in-service component where the expertise of teachers, psychologist, guidance counsellors, and subject area consultants within the School Board was effectively utilized since staff knew each other and were familiar with existing curriculum.

VI. ADDITIONAL CONSIDERATIONS - REPORT FROM PROJECT TEAM

Those persons within the School Board closely associated with the Mobile Clinic viewed the project as an overwhelming success during its inception year. Although numerous organizational problems, staff constraints, and logistical problems required an enormous expenditure of time and energy, the positive feedback provided by most teachers, students and administrators can only underline its success. The clinic animator was most pleased with the success of the program as were the special education consultants. However, it should be noted that the project team, that is the Laurenval Team (Clinic Animator, Special Education Consultants) have made the following important suggestions to enhance the effectiveness of the program:

1. Since numerous organizational difficulties were encountered and the organizational aspects of the program require a significant amount of time and energy if it is to be effective, a part-time coordinator whose responsibilities would be coordination between and within schools, organizational duties, selection of students, transmission of information to administrators, etc. should be appointed.
2. A formally recognized budget which would allow for the purchasing of educational materials and pertinent bibliographic references, xeroxing, and minor travel allowances for teachers participating in the Mobile Clinic should be included.
3. Numerous constraints and contractual arrangements often

preclude the hiring of the animator/master teacher. In essence, the role of the animator is one of a psychologist who has had classroom experience and is knowledgeable in educational materials and intervention strategies. In order to attract such a person a lucrative salary must be offered as well as an ample amount of time to advertise the position to ensure the engagement of the most highly qualified person.

4. It is also important to note that attendance at the Mobile Clinic was on a voluntary basis and thus many of the teachers who might have benefitted from the clinic may well have not participated in such an endeavor for fear of the work load, travel constraints, etc. However, as the clinic has gained in popularity, it would be hoped that on a rotational basis administrators in consultation with their staff could make recommendations as to the teacher/teachers attending the clinic.
5. As many teachers were somewhat reluctant to participate in the clinic for fear of leaving their regular classroom for three weeks there should be a substantial time allocation during which teachers could meet with their substitutes in order to best plan the educational goals of their home room class.
6. More involvement should be aimed at including the parents of the clinic children in order to help reinforce the concepts learned during the clinic intervention. As well, more follow-up between clinic and host teachers, is necessary in order to maintain an ongoing progress report for each child.

VII. RECOMMENDATIONS

The research data, clinical evaluations, and interviews fully support the effectiveness of the Mobile Clinic model in helping teachers prepare themselves for working with children with minor learning and behavior problems in the regular classroom setting. This model, following the theoretical rationale of mainstreaming, is viewed as an essential and integral part of each school in preparing, retraining and providing the necessary support structures to enable teachers to help integrate children into the regular classroom setting. The Mobile Clinic within the Laurenval School Board has served this purpose well while taking into account its geographical territory and the clientele it serves. It is essential to reiterate that this report has analyzed the data from only four of the eight clinics and that these clinics served English speaking elementary school teachers. Before these results can be generalized it is imperative to provide a more thorough evaluation utilizing a larger group of students and teachers. The results also indicate that students attending the clinic make adequate progress and do not suffer any apparent detrimental effects from having been away from the regular classroom setting. Thus, it is recommended that the Mobile Clinic be continued within the School Board and be viewed as a viable alternative to traditional mainstreaming programs. Significant advantages of this program are its practical clinical nature, and the fact that it permits teachers to receive on-the-job training while maintaining their regular salary. More

specifically, the recommendations are as follows:

1. All evaluations clearly point to the prominent role that the special education consultants, and in particular the clinic teacher, played in the Mobile Clinic. It is essential that someone who has an indepth knowledge of the workings of the School Board (e.g. Special Education Consultant), has a knowledge of the case histories of many of the children who have been experiencing learning and/or behavioral problems, and who is familiar with the programs and materials available within the School Board, be actively incorporated within the Mobile Clinic Model and be given an appropriate release of time.
2. It is recommended that the administration within each school be fully aware of the objectives, goals, and research components of the program in order to best communicate this information to the teaching staff.
3. Since in-service training appeared to be one of the most beneficial aspects of the program, a greater number of teachers in the Host School should be allowed to attend such in-service workshops.
4. While the Mobile Clinic during its inception year within the Laurenval School Board operated on a 'three week' model no evaluation was conducted on whether or not a two week model is viable and as effective. A two-week model would serve to increase the number of teachers who may participate in the

program, increase the number of students participating in such a clinic, and reduce the anxiety of participating teachers concerning the academic progress of their pupils within their regular classroom.

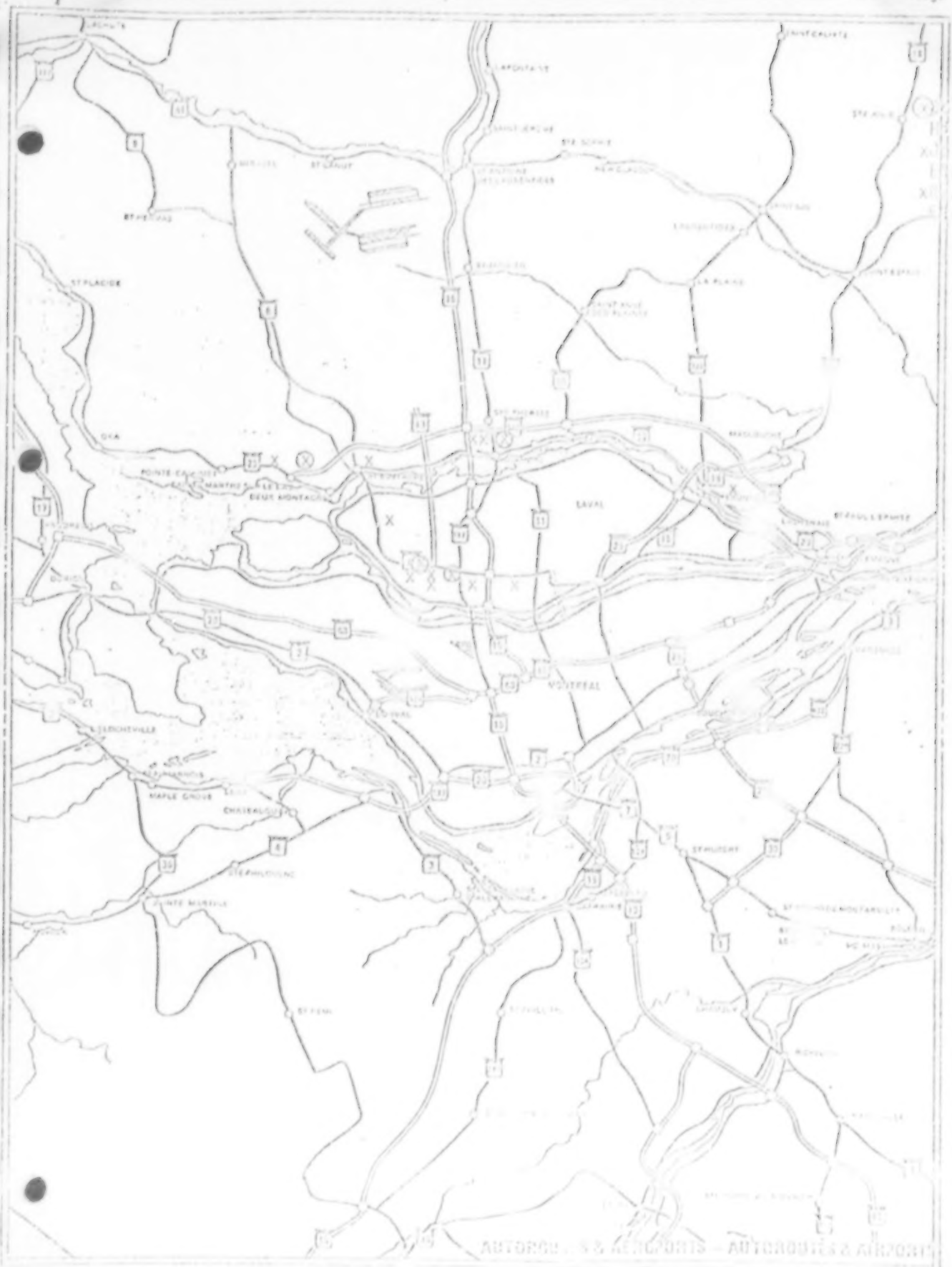
5. Contact with the departments of special education within the local universities should be encouraged in order to examine the feasibility of providing closer liason, sharing of materials, expertise and to explore the possibiity of teachers receiving university credit for attendance in the clinic. As well, the university might provide additional complementary university level courses.
6. Since the present evaluation only examined four anglophone elementary schools a closer evaluation of the Mobile Clinic for Secondary Schools is warranted.

VIII. SUMMARY AND CONCLUSIONS

The research, clinical, and observational data indicate that the Mobile Clinic has met many of its objectives during its inception year. Teachers view the Mobile Clinic as a very positive experience during which they have gained insight about successful diagnostic, prescriptive, and remedial techniques and methods which may be employed in the regular classroom. While no appreciable gains in academic performance were noted for students participating in the clinic, neither were there any appreciable decreases as a result of being removed from their regular home

room period for a three week interval. Within the elementary schools, considering the geographic organization of the Laurenval School Board, the Mobile Clinic is viewed as an integral and viable mechanism for retraining and re-educating teachers to effectively work with children with minor learning and behavioral problems within the regular classroom setting. It must be remembered that the effectiveness of a Mobile Clinic program such as the one implemented in the Laurenval School Board is highly dependent upon the skills and capabilities of the animator and supporting staff. This model has tremendous potential to attract teachers who would not likely engage in any further professional training and can be considered a viable mechanism for enhancing mainstreaming activities.

APPENDIX A - SCHOOL BOARD INFORMATION


ST PLACIDE
STE SCHOLASTIQUE
STE ANNE
LA PLAINE
OKA
POINTE CALUMET
MARTHE
DEUX MONTAGNES
LAVAL
MONTREAL
ST EUSTACHE
ST BLAISE
ST LAZARE
ST HILAIRE
STE MARTHE
ST FERMI
ST HUBERT
MONTARVILLE
BOUCHERVILLE
MAPLE GROVE
CHATEAUGUAY
AUTOROUTES - AUTOSTRADE - AUTOBAHNEN - AUTOPISTAS

CLUBS BY KILOMETERS ST-EUSTACHE 25/SC	A.H.	A.H.S.	A.S.	C.M.	D.H.S.	E.H.	ST-EUST.	LAVAL	MONTCLAIR	N.D.	N.D.D.	ORMSB.	S.C.	
C.H.S.	0	3.7	18.3	18.3	84.8	5.5	3.7	16.1	3.4	8.6	2.1	9.1	2.1	3
V.J.H.S.	3.7	0	15.2	17.8	90.1	2.8	1.8	15.4	2.0	6.0	3.9	12.8	4.7	
R.H.S.	18.2	15.7	0	21.8	88.0	22.5	19.2	18.0	14.9	20.9	13.1	28.8	18.8	14
N.-D.-D.H.S.	18.3	17.8	21.8	0	85.3	22.7	24.3	5.5	24.7	21.1	22.2	33.8	16.1	17
P.H.S.	81.8	90.1	88.6	85.3	0	87.4	88.5	87.1	89.0	89.8	77.2	72.6	86.4	88.
L.H.H.	5.2	2.8	22.5	22.7	87.4	0	2.2	13.6	2.4	4.4	5.2	13.8	5.2	2
CHAMPLAIN	3.7	1.8	19.2	24.3	88.5	2.1	0	14.8	1.3	5.4	4.2	12.5	3.9	1
LAVAL WEST	16.1	15.4	18.0	5.5	87.1	13.6	14.8	0	15.1	14.1	17.8	21.9	16.2	15
MONTCLAIR	3.4	2.0	14.9	24.7	89.0	2.4	1.3	15.1	0	5.7	2.9	11.4	2.8	1
NOTRE DAME EST	8.6	6.0	20.9	21.1	89.8	4.4	5.4	14.1	5.7	0	6.6	17.0	8.4	5
PENTAGONE	2.1	3.9	13.1	22.2	77.2	5.2	4.2	17.8	2.9	9.6	0	11.2	3.8	3
CORBIN	9.1	12.8	20.8	32.9	72.6	13.8	12.5	21.9	11.4	17.0	11.2	0	8.6	12
N.D./DU LIONS	2.1	4.7	18.8	20.1	86.4	5.2	3.9	16.2	2.8	8.4	3.9	8.6	0	4
SOUVENIR	3.2	.5	14.9	17.0	89.8	2.4	1.3	15.1	1.8	5.7	3.6	12.5	4.4	0
TWIN OAKS	8.1	8.4	11.8	9.7	80.4	8.8	9.9	6.7	10.2	10.1	6.7	17.8	10.9	8
ST. EUSTACHE	17.5	15.5	13.5	8.1	77.2	14.6	15.7	6.3	16.1	13.0	18.8	15.6	19.1	13
LEWIS KING	33.9	33.2	17.7	34.4	92.0	36.5	37.6	36.2	38.1	38.6	26.3	21.7	35.5	39
BOISBOIS	13.1	12.2	3.1	18.5	71.7	21.1	13.1	15.6	11.8	17.8	10.1	16.4	15.7	11
ROLAND	80.8	86.1	64.6	81.3	42.4	83.4	84.5	83.1	85.0	85.8	73.2	68.6	82.4	85
JOLIETTE ELEM.	85.5	84.3	67.3	84.0	1.3	86.1	87.2	85.8	87.7	88.2	75.9	71.3	85.1	85
MOUNTAINVIEW	19.9	19.1	19.9	1.6	83.7	21.1	22.7	7.1	23.0	19.5	23.8	31.3	24.5	18
McCAIG	15.9	14.9	.3	21.2	68.9	22.2	15.0	17.5	14.6	20.6	12.8	20.4	18.5	15
A.V. CENTRE	13.1	12.2	3.1	18.5	71.7	21.1	13.1	15.6	11.8	17.8	10.1	16	15.7	11
CURRICULUM	13.1	12.2	3.1	18.5	74.7	21.1	13.1	15.6	11.8	17.8	10.1	16.4	15.7	11
ALOS VICTOR MORIN	7.0	10.7	20.9	35.1	74.1	13.0	11.8	22.1	10.5	15.9	10.4	2.4	7.6	10
N.A.A.T.N.														

T BY CMETERS UNDY 23/SC	P.H.S.	L.N.S.	R.H.S.	L.T.M.E.S.	J.H.S.	S.P.H.	CRESTVIEW	LAVAL WEST	HILLCREST	PEL	PARKDALE	CORDON	P.C./[illegible]	SOUVENIR	TWIN OAKS	ST. ELIZA	LEWIS ST.	PLYMPTON	MARMION	[illegible]	[illegible]	PECAN	N.W. CEN	[illegible]	[illegible]	N.I.
.S.	0	3.7	16.2	18.3	84.8	5.2	3.7	16.1	3.4	8.6	2.1	9.1	2.1	3.2	3.1	17.5	33.9	13.1	80.8	83.5	[illegible]	15.2	13.6	13.1	7.0	
.S.	3.7	0	15.2	17.5	90.1	2.8	1.5	15.4	2.0	6.0	3.9	12.8	4.7	.5	9.4	13.5	39.2	12.2	86.1	84.8	[illegible]	14.0	12.2	12.2	10.7	
S.	16.2	15.2	0	21.6	68.6	22.5	16.2	18.0	14.9	20.9	13.1	20.8	18.8	14.9	11.8	13.5	17.7	3.2	84.6	87.3	[illegible]	.4	3.2	3.1	22.1	
N.H.S.	18.3	17.5	21.6	0	85.3	22.7	24.3	5.5	24.7	21.1	22.2	22.9	26.1	17.3	9.7	8.1	54.4	13.5	81.3	8.4	[illegible]	21.2	19.5	19.5	33.1	
S.	83.8	80.1	85.6	85.3	0	87.4	88.5	87.1	89.0	[illegible]	77.2	72.6	86.4	89.8	80.4	77.2	52.0	71.7	42.4	1.3	[illegible]	68.8	71.7	71.7	74.1	
N.	5.3	2.6	12.5	22.7	87.4	0	2.1	13.6	2.4	4.4	5.2	13.8	5.2	2.4	8.8	14	[illegible]	21.1	83.4	86.1	[illegible]	22.2	21.1	21.1	25.1	
STVILL	3.7	1.9	16.2	24.3	88.5	2.1	0	14.8	1.3	5.4	4.2	12.5	3.9	[illegible]	9.9	15.7	37.8	13.1	84.5	87.2	[illegible]	15.8	13.1	13.1	[illegible]	
L WEST	16.1	15.4	18.0	5.5	87.1	13.6	14.8	0	15.1	14.1	17.8	21.9	16.2	15.1	6.7	6.3	36.2	15.6	83.1	85.8	[illegible]	17.3	15.6	15.6	22.1	
WEST	3.4	2.0	14.9	24.7	89.0	2.4	1.3	15.1	0	5.7	2.9	11.4	2.8	1.8	10.2	16.2	38.1	11.8	85.0	87.7	[illegible]	15.8	11.8	11.8	[illegible]	
NE LAFONTE	8.6	8.2	20.9	31.1	89.5	4.4	5.4	14.1	5.7	0	[illegible]	17.0	8.4	5.7	10.1	13.0	38.6	17.8	85.8	88.2	[illegible]	20.6	17.8	17.8	[illegible]	
NVME	2.1	3.9	13.1	22.2	77.2	5.2	4.2	17.8	2.9	9.6	0	11.2	3.9	3.6	6.7	19.8	26.3	10.1	73.2	75.9	[illegible]	12.8	10.1	10.1	19.3	
ON	9.1	12.6	20.8	32.0	72.6	13.8	12.5	21.8	11.4	17.0	11.2	0	8.6	12.5	17.8	25.6	21.7	16.4	68.6	71.3	[illegible]	20.4	16.4	16.4	2.4	
/ILLIGUES	2.1	4.7	18.8	26.1	86.4	5.2	3.9	16.2	2.8	8.4	3.9	8.6	0	4.4	10.9	19	35.5	15.7	82.4	85.1	[illegible]	18.8	15.7	15.7	[illegible]	
ENIR	5.2	.5	14.9	17.0	89.8	2.4	1.3	13.1	1.8	5.7	3.6	12.5	4.4	0	8.9	18.1	38.9	11.8	85.8	88.5	[illegible]	15.6	11.8	11.8	20.4	
OAKS	8.1	9.4	11.8	9.7	80.4	8.8	9.8	6.7	10.2	10.1	6.7	17.8	10.9	8.9	0	7.5	29.5	8.8	76.4	79.1	[illegible]	13.5	8.8	8.8	18.1	
USTACHE	17.9	13.8	13.5	8.1	77.2	14.8	13.7	6.3	16.1	13.0	19.8	15.6	19.1	13.1	7.5	0	36.3	10.4	75.2	75.9	[illegible]	13.1	10.4	10.4	25.1	
S KING	33.9	32.2	17.7	34.4	92.0	36.5	37.6	30.2	38.1	38.6	26.3	31.7	35.5	38.9	29.5	26.3	0	20.8	46.9	50.7	[illegible]	18.0	20.8	20.8	33.8	
OOD	13.1	12.2	3.1	18.5	71.7	21.1	13.1	15.6	11.8	17.8	10.1	16.4	15.7	11.8	8.8	10.4	20.8	0	67.7	70.4	[illegible]	2.8	0	0	17.8	
CY	80.8	86.1	84.6	81.3	42.4	85.4	84.5	83.1	85.0	85.8	75.2	68.6	82.4	85.8	76.4	73.2	46.9	67.7	0	41.1	[illegible]	84.9	87.7	87.7	70.1	
TTE ELEN	83.5	84.3	67.3	84.0	1.3	86.1	87.2	85.8	87.7	88.2	75.9	71.3	85.1	88.5	79.1	75.9	50.7	70.4	41.1	0	[illegible]	67.6	70.4	70.4	72.8	
TAINVIEW	19.9	19.1	19.9	1.6	83.7	21.1	22.7	7.1	23.0	19.5	23.8	31.3	24.5	18.7	11.4	6.5	32.8	16.9	78.7	82.4	0	19.6	16.9	16.9	31.5	
IG	15.9	14.9	.3	21.2	68.9	22.2	15.9	17.5	14.6	20.6	12.8	20.4	18.5	15.6	11.5	13.1	18.0	2.8	64.9	67.6	[illegible]	0	2.8	2.8	20.1	
CENTRE	13.1	12.2	3.1	18.5	71.7	21.1	13.1	15.6	11.8	17.8	10.1	16.4	15.7	11.8	8.8	10.4	20.8	0	67.7	70.4	[illegible]	2.8	0	0	17.8	
CULOM	13.1	12.2	3.1	18.5	71.7	21.1	13.1	15.6	11.8	17.8	10.1	16.4	15.7	11.8	8.8	10.4	20.8	0	67.7	70.4	[illegible]	2.8	0	0	17.8	
VICTOR MORIN	7.0	10.7	20.9	33.1	74.1	13.0	11.8	22.1	10.5	15.9	10.4	2.4	7.6	10.4	18.0	25.8	23.2	17.8	70.1	72.8	[illegible]	20.6	17.8	17.8	0	
.T.M.																										

LAURENVAL SCHOOL BOARD

OFFICIAL SECONDARY SCHOOL ENROLLMENTS - SEPTEMBER 30, 1980

	TOTAL 79-80	Sec.1	Sec.2	Sec.3	Sec.4	Sec.5	TOTAL
CPHS	1494	227	241	248	311	345	1372
LTDHS	705	144	119	123	146	128	660
RHS	1413	245	230	264	303	283	1325
JHS	292	59	76	68	49	36	288
WLHS	1398	268	253	293	294	285	1393
TOTAL		943	919	996	1103	1077	5038
TOTAL 79-80	5302	912	1046	1137	1109	1098	5302

GZ/pl.

1980-11-07

LAURENVAL SCHOOL BOARD

OFFICIAL ELEMENTARY SCHOOL ENROLLMENTS - SEPTEMBER 30th, 1980

	C.A.4	C.A.5	Kind	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6	TOTAL
Crestview	--	--	13	30	28	33	41	58	68	271
Elmwood	--	--	17	35	27	34	55	47	63	278
Gordon	--	--	32	49	24	32	40	45	42	264
Hillcrest	--	--	18	27	29	34	47	45	42	242
I.B.M.	--	--	71	54	76	86	83	99	105	574
Joliette	--	--	--	3	4	11	15	21	26	80
Lewis King	--	--	13	25	17	15	17	17	14	118
McCaig	--	--	22	44	41	37	41	50	44	279
ountainview	--	--	37	36	40	50	40	51	45	299
Pierre Laporte	53	59	--	68	60	62	32	26	43	403
Pr.Ch./THB	--	--	34	22	49	46	67	67	78	363
Rawdon	--	--	14	23	25	17	24	18	23	144
Souvenir	--	--	21	59	53	60	94	110	103	500
Twin Oaks	--	--	25	19	42	35	35	37	28	221
V. des Jeunes	39	34	19	29	34	27	17	23	14	236
TOTAL	92	93	336	523	549	579	648	714	738	[illegible]72

GZ/pl.

320-11-07

LAURENVAL SCHOOL BOARD

OFFICIAL ELEMENTARY SCHOOL ENROLLMENTS - SEPTEMBER 30th, 1980

FRENCH IMMERSION

	Total 79-80	Crestview	IBM	P.Charles	Souvenir	Elmwood	Total
Kindergarten	104	13	36	19	21	--	89
Level 1	91	19	23	22	24	--	88
Level 2	106	13	27	21	23	--	84
Level 3	102	18	37	15	17	--	87
Level 4	95	13	33	29	25	--	100
Level 5	121	12	33	18	26	11	100
Level 6	96	23	40	13	28	9	113
Level 6+	24	--	--	--	21	--	21
TOTAL	739	111	229	137	185	20	782

GZ/pl.

1980-11-07

LAURENVAL SCHOOL BOARD

OFFICIAL ELEMENTARY SCHOOL ENROLLMENTS - SEPTEMBER 30th, 1980

FRENCH FIRST LANGUAGE

	Total 79-80	Gordon	Pierre Laporte	Village des Jeunes	TOTAL
C.A. - 4yr olds	80	--	53	39	92
C.A. - 5yr olds	57	--	59	34	93
Kindergarten	32	18	--	19	37
Level 1	82	27	52	29	108
Level 2	90	11	47	34	92
Level 3	36	19	43	27	89
Level 4	31	12	16	17	45
Level 5	22	15	--	23	38
Level 6	18	17	--	14	31
TOTAL	448	119	270	236	625

GZ/pl.

1980-11-07

In recent years a steadily increasing number of Greek families have chosen to domicile in the City of Laval. A survey of the numbers of Greek children enrolled in certain schools under the Board's jurisdiction follows:

School	Total Enrollment	No. of Greek Children	% of School of Greek Origin
P. Charles/T.H. Bowes	363	127	35%
Crestview	271	64	24%
Irving Bregman	574	178	31%
Hillcrest	242	133	55%
Souvenir	500	136	27%
Pierre Laporte	403	251	62%
Chomedey Polyvalent	1572	390	28%
Western Laval	1393	301	22%
Total	5118	1580	31%

APPENDIX B - MOBILE LEARNING CLINIC - SELECTION OF STUDENTS

LAURENVAL MOBILE LEARNING CLINIC:

SELECTION OF STUDENTS

i. Criteria for Selection of Students

Students who may benefit from the Clinic experience are as follows:

- those with one marked subject area weakness i.e. Mathematics, Language Arts.
- those students who have been recently re-integrated from a Special Education class, into a full time regular class.
- those with moderate or questionable learning difficulties.
- those who exhibit disorganization, poor attention span, poor self confidence, low motivation and/or poor work habits.
- those students who exhibit perceptional motor difficulties i.e. fine-motor poor handwriting.
- those students with second language difficulties that affect academic performance.
- those students for whom short term intensive help, may markedly improve performance in regular class.
- those students who are under achieving.

Please note that the following students will not be candidates for the Learning Clinic.

(a) students currently in self-contained Special Education classes.

(b) students with severe emotional and behavioral problems.

ii. Procedure for Selection of Students

1) The Principal, Vice Principal, the regular class teacher the Free Flow teacher and/or the responden , psychologist, counsellor , may be involved in the selection of students

for clinic. Please note that selected student may receive more intensive remedial help than in Free Flow (30 minutes to 2 hours per day).

2) The referring teacher(s) will be asked to complete a simple information sheet on the student. Classroom teacher will get practical feedback, after the clinic, if the student is selected to attend.

3) The Principal will provide a list of 8 - 10 possible students and the information sheets on each student to your Special Education Consultant, one week prior to the starting date of the Clinic in your school.

4) The Principal should inform the parents of the students selected to participate in the clinic.

Sample information sheet on student filled by classroom teacher (reading) to clinic

WRITE LEARNING CLINIC

Student Information Sheet

Name: _____ Age: _____ Grade: _____

Class Teacher(s): _____

i. Reasons for attending clinic: _____

ii. Specific Strengths/Interests: _____

iii. Specific Weaknesses: _____

iv. Behavior/Work Habits: _____

v. Is the student currently receiving Free Flow? ☐ Yes ☐ No

vi. What are the materials/programmes being used in the area of difficulty? _____

vii. What would you like to see this student accomplish during the three-week clinic? _____

_____ _____

Date Completed Signature

APPENDIX C - HIRING CONSTRAINTS

1981-02-17

Constraints of Hiring the Mobile Clinic/Mainstreaming Supervisor/Animator

Some of the Profoundest problems in the hiring of the supervisor were:

1) Our Pedagogical staff (teachers et al) refused to bid for the position unless they were offered a leave of absence for the year involved and an assurance to re-enter the ranks of the teachers.

   The teachers union, N.I.L.T.U. opposes such leaves of absence from teaching for such purposes. This made it difficult, if not impossible, to select a supervisor for such a one year pilot project from amongst the experienced, special education teachers of our system.

2) With the above in mind, the candidates from outside our system were too few in number because of the experience, the training (prescriptive and diagnostic) required. Moreover, the one year pilot project, without any assurance of any continuation of the project after one year, militated against tenured, experienced teachers, consultants, or administrators from other boards applying for the position.

Bruce Campbell
/js

APPENDIX D - MATERIALS USED IN CLINIC

LIST OF READING MATERIALS USED
AND DISPLAYED IN CLINIC

JOURNALS:

Reading Teacher
Teacher
Arithmatic Teacher
Academic Therapy
Journal of Exceptional Children
Journal of Child with Learning Disabilities (J.L.D.)
Psychiatric Quaterly
Pamphlets (1) Council for Exceptional Children
(2) QACLD.

BOOKS:

Teaching Remedial Reading - Lillie Pore
The Story of Dibbs
Math Teacher - Persis Herold
Montessori for the Disadvantaged - R.C. Orem
The Exceptional Child in the Family - Allan Ross
No Easy Answers - Sally L. Smith
Learning Disabilities principals and practices - Mykelbust Johnson
Aids to Psycholinquistic teaching - Bush - Giles
Understanding Piajet - Pulaski
Educational Assessment of Learning Problems - Wallace Larsen
Children with Learning Disabilities - Lerner
Learning Disabilities - Educational Strategies 2nd ed. - Greenhart
Diagnosing Learning Disabilities 2nd ed. - Bush, Waugh
Reading and Learning Disabilities - Kaluger, Kolson
Solutions to reading problems - Heckelman R.G.
Training that makes sense - Kirshner (Dr.)
Learning to read - Chall
Behavior of exceptional children - Haring
The myth of the hyperactive child - Schrag -Divoky
Children's arithmetic - Ginsburg
Analysis of error patterns in math - Ashlock
The exceptional child grows up - Segal Earnest
Square pegs round holes - Harold B. Levy
Reading in childhood language disorders - Lahey M.
Conflict in the classroom - Nick Long, Morse, Newman
Towards humanistic education - Fantini

TESTS USED IN MOBILE LEARNING CLINIC

1) General Achievement Tests

    1. WRAT (Wide Range Achievement Test)

2) Intelligence Tests

    1. Weschler Intelligence Scale for Children - Revised
    2. Slosson Intelligence Test

3) Perceptual - Motor Tests

    1. Developmental Test of Visual Motor Integration (Beery Buktenica)
    2. Frostig Test of Visual Perception
    3. Bender - Gestalt Test of Visual Perception
    4. VADS - Visual - Auditory Digit Span Test

4) Reading and Spelling Tests

    1. Woodcock Reading Mastery Tests
    2. Spache Diagnostic Reading
    3. Durrell Analysis of Reading Difficulties
    4. Slingerland Test of Language Disabilities
    5. Stanford Diagnostic Reading Test
    6. Gates - McKillop Reading Test
    7. Gray Oral Reading Test
    8. Informal Reading and Spelling Inventories

5) Written Language Tests

    1. Test of Written Language

6) Mathematics Tests

    1. Key-Math
    2. Stanford Diagnostic Mathematics
    3. Metropolitan Achievement Math

APPENDIX E - RESEARCH INSTRUMENTS

Appendix E

TEACHER QUESTIONNAIRE*

Prepared by:

Janyne Rahming
Lois Tétreault

for

Office of Research on Educational Policy
Administration and Policy Studies
Faculty of Education
McGill University

November 1980

*Adapted from Gickling and Theobald (1975) and Paul, Turnbull and Cruickshank (1977)

TEACHER QUESTIONNAIRE

This research project requires that information be obtained from those involved in the Clinic Project, and we are, therefore, seeking your cooperation in the completion of this questionnaire booklet.

First you will be asked to supply some biographical information. The rest of the questionnaire has been divided into four sections. The first section is aimed as sampling general information concerning exceptional children. The second is concerned with obtaining your views as to which types of children require which types of educational services. The third is less specific and is intended to survey a wide range of topics related to special education. The fourth section samples knowledge of programs and techniques.

You will find specific instructions for each section as you complete the booklet. Do not hesitate to ask for clarification if required.

Thank you for your cooperation.

Please read and sign the following consent form:

I have been informed of the purpose of this questionnaire. The answers I give to the following questions will not be revealed to anyone but the research assistant, who will prepare the data using arbitrarly assigned identification numbers.

Signed: _____

BIOGRAPHICAL INFORMATION

Name: _____ Date: ____ ____ ____
year month day

Sex: ☐ Male ☐ Female

Please indicate age range:

☐ 20 - 30 ☐ 31 - 40 ☐ 41 - 50 ☐ 51 - 60

Please give a brief description of your academic and professional background:

Academic: highest degree completed _____ when _____ from which University?

_____

Professional: What teacher training program? _____

Where? _____

Any areas of specialization?

Specialist Diplomas? _____ When? _____

Any other qualifications: _____

_____

_____

Please indicate the total number of full time years of teaching experience you have:

☐ 1 - 5 ☐ 6 - 10 ☐ 11 - 15 ☐ 16 - 20

☐ 21 - 25 ☐ 26 - 30 ☐ 31 - 35 ☐ over 35

Grade level currently teaching:

☐ Kindergarten ☐ 1 - 3 ☐ 4 - 6 ☐ Secondary I

☐ Secondary II

What is the total enrolment in the class you are currently teaching?

_____

How many of your students, based on your present knowledge have the following problems?

Learring Disabilities _____
Slow Learners _____
Mild mental retardation _____
Emotional difficulties _____
Other (specify) _____

Have you taken any courses in the Special Education or Exceptional child area?

Yes ____
No ____

If yes, how many?

1 - 3 ____
4 - 7 ____
8 - 10 ____
over 10 ____

What do you hope to gain from this clinic experience?

PART I

The following is a general information inventory. Please write the letter corresponding to your response in the blank provided.

____ 1. The major goal of training programs for the child with mild mental retardation is:

a) social adequacy
b) academic proficiency
c) occupational adequacy
d) occupational adjustment

____ 2. The emotional needs of the child with mild mental retardation are:

a) stronger than normal children
b) the same as normal children
c) not as strong as normal children
d) nothing to be particularly concerned with

____ 3. The proper placement for the slow learner (IQ 75-90) is in:

a) the regular classroom
b) special class
c) vocational arts
d) regular class until age of 16 and then dropped out of school

____ 4. In school, the slow learner usually:

a) is given a lot of successful experiences
b) meets with a great many failures
c) is a leader
d) is aggressive

____ 5. In grading the slow learner, the teacher should:

a) be realistic: if the child is a failure, fail him
b) grade him according to his achievement in relation to his ability
c) not be particularly concerned with a grade
d) grade him according to his IQ

____ 6. The child with mild mental retardation is:

a) potentially employable
b) potentially unemployable
c) educable
d) just slightly below average in intelligence

____ 7. The child with mild mental retardation:

a) looks quite different from other children
b) is in need of an educational program especially designed for his needs and characteristics
c) can never be self-supporting
d) cannot benefit from any program

____ 8. The mentally handicapped individual usually becomes:

a) skilled craftsman
b) a professional person
c) a semi-skilled or unskilled laborer
d) unemployable

____ 9. The learning disabled child:

a) has at least average intelligence
b) has superior intelligence only
c) always has retarded intelligence
d) may have somewhat retarded, average, or superior intelligence

____ 10. The most common educational handicap of the learning disabled is:

a) reading
b) arithmetic
c) spelling
d) geography

____ 11. The mentally handicapped usually have:

a) inferior motor development
b) superior motor development
c) superior physical development
d) above-average motor development

____ 12. The reaction of the public toward the retarded child seems to be:

a) rejecting
b) somewhat understanding but not completely accepting
c) accepting
d) to express feelings of acceptance though really feel rejection

____ 13. The congenital deaf child will probably display:

a) articulatory errors
b) voice abnormalities
c) retarded language growth
d) all of the above

____ 14. The deaf, deafened, and hard-of-hearing are different categories based mainly on:

a) degree of hearing loss
b) speech development
c) lip reading ability
d) amount of hearing loss and age of onset

____ 15. Disorders of articulation refer to all of the following <u>but one</u>:

a) omission of sounds
b) pitch
c) distortion of sounds
d) substitution of sounds

____ 16. Stuttering is often the result of:

a) cleft palate
b) emotional problems
c) malformation of the teeth
d) brain lesions

____ 17. The most common speech problem among elementary school children is:

a) functional articulatory problems
b) cleft palate speech
c) stuttering
d) voice problems

____ 18. Slow learners:

a) will read at grade level
b) will read at a level below normal children, but will come closer and closer to grade level as they progress through the grades
c) will read behind other children and will tend to fall further and further behind as they grow older.
d) will succeed with traditional reading programs in the regular grades

____ 19. The intellectual ability of cerebral palsy children as a group is:

a) normal
b) above normal
c) below normal
d) impossible to evaluate

____ 20. The classroom to be used for teaching learning disabled children should be:

a) very colorful
b) include much stimuli
c) have ample window area
d) have a minimum amount of stimuli

____ 21. Anoxia is a condition in which the brain:

a) receives insufficient oxygen
b) is underdeveloped
c) is too large
d) has suffered from hemorrhage

____ 22. One of the most commonly found characteristics of children with learning disabilities is:

a) disorders of speech and hearing
b) the neuroallergic syndrome
c) below average intelligence
d) hyperactivity (p. 72)

____ 23. Poliomyelitis is caused by:

a) heredity
b) Rh factor
c) a virus
d) lack of rest

____ 24. Before one can conclude that a child has a learning disability one must determine:

a) the causes of minimal brain dysfunction
b) if there is a discrepancy between the child's estimated ability and actual performance
c) if there is a discrepancy between the child's personal goals and the child's personal attainment
d) if there is a significant difference between intelligence and cultural opportunity

____ 25. If one of your pupils has an epileptic seizure you should:

a) leave the room to get help
b) keep him from getting into a dangerous position
c) stick your fingers in his mouth to keep him from biting his tongue
d) rush all of the children out of the room

____ 26. Learning disabled children often have difficulty in completing assigned tasks due to:

a) faulty work habits such as lack of attention to directions
b) insufficient cognitive development due to slight mental retardation
c) inability to follow directions due to impaired hearing
d) none of the above

____ 27. Social and emotional maladjustment in physically handicapped children:

a) is present in all cases
b) can be related to their mental ability
c) is dependent upon the number and severity of the problems
d) is less of a problem than in normal children

____ 28. The attitudes of parents toward their physically disabled child tend to be:

a) oversolicitous, rejecting
b) accepting, understanding
c) the same as toward their normal children
d) more positive than toward their normal children

29. The prevailing attitude of regular class teachers toward handicapped children is:

a) verbalized acceptance but somewhat rejecting;
b) completely accepting;
c) the same as toward normal children
d) more understanding.

30. The responsibility for the education of exceptional children should be placed upon:

a) the local school districts;
b) the community;
c) the province
d) the parents of the exceptional children.

31. The blind:

a) have superior sensory acuity;
b) pay attention to auditory cues more than do seeing people;
c) develop a sixth sense;
d) have markedly superior musical ability.

32. The most helpful attitude toward the blind child's achievement is:

a) sympathetic;
b) nonsentimental;
c) emotional;
d) narcissistic.

33. In a school situation, the intellectually gifted differ most from the average in:

a) physical development;
b) motor abilities;
c) participation in athletics;
d) academic achievement.

34. If repetition of a task is imposed by the teacher in such a manner that the child feels that he is failing, he will usually:

a) work harder in order to find success;
b) discover a technique of avoidance;
c) gain new insights;
d) become encouraged.

35. Probably the handicap which is the most widely rejected by society is:

a) visual handicap;
b) orthopedic handicap;
c) hearing handicap;
d) behavior disorder.

PART II

Teachers are ordinarily faced with a wide variety of problems arising from the many different kinds of students they work with each day. On the following pages you will find brief descriptions of the behavior of a number of exceptional children. In each case you are to indicate how you would prefer to handle the situation if the decision were entirely up to you.

Read each item and write the letter corresponding to your choice as follows:

A. If you feel you could handle such a student in your regular classroom without any fundamental change in your present procedures.

B. If you feel you could handle such a student in your regular classroom provided advice from a specialist, such as speech therapist, psychologist, social worker, was occasionally available upon request. Exclude the need for strictly medical attention from this category.

C. If you feel you could handle such a student in your regular classroom provided there was a full-time specialist, such as a free flow teacher, available at your school who could provide supplementary training for the student and frequent consultation with you.

D. If you feel that such a student would benefit most by being assigned to a self-contained special class.

E. If you feel that such a student would benefit most by being place in a special school.

Mark each item according to this code:

A. Regular classroom
B. Part-time, occasional aid
C. Full-time aid
D. Special class
E. Special school

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Mark each item according to this code:

A. Regular classroom
B. Part-time, occasional aid
C. Full-time aid
D. Special class
E. Special school

____ 1. Alfred is defiant and stubborn, likely to argue with the teacher, be willfully disobedient, and otherwise interfere with normal classroom discipline.

____ 2. Barbara wears thick glasses, and her eyeballs jerk spasmodically from side to side; she can't see the blackboard very well, and she reads poorly.

____ 3. Chuck can get about only in a wheelchair; someone must move it for him, or carry him in their arms, because he is unable to control any of his limbs.

____ 4. Donald is six years old and does not speak very much; what he does say is indistinct and childish, with many missing or incorrect sounds.

____ 5. Earl is eight and wears cowboy boots to class because he hasn't learned to tie his own shoe laces; he is generally cheerful and well-behaved, but talks very little and is incapable of following any but the most simple instructions.

____ 6. Florence is immature and oversensitive, likely to burst into tears at the slightest provocation.

____ 7. When Alice wears her hearing aid she hears as well as any other youngster; her voice sounds flat and hollow, and is somewhat unpleasant to hear.

____ 8. Suzy frequently gets so excited she loses control of herself and wets the floor.

____ 9. Ruth is very much like other eleven-year-olds in most respects but occasionally, during the day, a rhythmical quiver will pass over her face and she becomes totally oblivious for a few seconds.

____ 10. Roger's face was severely disfigured in an auto accident; although he is completely recovered physically, the surgeons do not expect to be able to make his appearance more acceptable for many years.

____ 11. Alan wears a leg brace and walks with the aid of crutches; he gets along quite well by himself though, and ordinarily needs no help from anyone.

____ 12. Bernard is a bully, given to teasing other children and provoking fights with them.

____ 13. Cora is supposed to have a hearing loss, but she seems to hear all right when she sits at the right end of the front row of seats.

Mark each item according to this code:

A. Regular classroom
B. Part-time, occasional aid
C. Full-time aid
D. Special class
E. Special school

____ 14. Clara has a noticeable scar on her upper lip; her speech seems to be coming through her nose, and she is hard to understand.

____ 15. Dotty is eight; she has difficulty following the class, and doesn't seem able to learn to read at all.

____ 16. Eight-year-old Edward sucks his thumb all the time, apparently indifferent to the reactions of parents, teachers, or other children.

____ 17. Every few weeks, without any warning, Stella will have a violent physical convulsion; after several minutes she returns to consciousness with severe headache, nausea, and acute feelings of depression.

____ 18. Flora has neither bladder nor bowel control and must be taken to the bathroom at frequent intervals.

____ 19. David squints through his eyeglasses, even when he sits at the front of the room, and cannot read the blackboard or his book quite as rapidly as many of the other children.

____ 20. Occasionally Edward will repeat a sound two or three times before he seems able to go on; he speaks when called on, but does not volunteer much.

____ 21. Chuck doesn't seem to catch on to things as quickly as most, and needs to have things explained over and over again; eventually, though, he appears to learn everything the others do even though it has taken longer.

____ 22. Doris is slow, absent-minded, and a daydreamer; she seems unusually quiet and withdrawn, avoids others, and is inhibited and restrained in her behavior.

____ 23. Every hour or so Henry stares upwards at the ceiling for several seconds and loses consciousness; he has been like this for several years but is otherwise developing normally.

____ 24. Fred can feel the vibrations of loud music from a radio or phonograph, knows when a door has been slammed, but does not hear speech unless it is shouted.

____ 25. Greg is nine years old and tires easily. He needs frequent opportunities to rest; excessive stimulation or excitement must also be avoided.

____ 26. Harold is a capable student but has a physical defect which appears to evoke laughter, ridicule, avoidance and rejection from the other children.

Mark each item according to this code:

A. Regular classroom
B. Part-time, occasional aid
C. Full-time aid
D. Special class
E. Special school

____ 27. Jane can tell the direction from which the sunshine enters her classroom; she cannot read the letters in an ordinary book.

____ 28. Albert does not pronounce all of his speech sounds correctly, but can be understood.

____ 29. Betty is only a little over seven but she can read the fifth-grade reader very well; her handwriting is poor though she is above average in most other things.

____ 30. Chester is deceitful, tells lies, and cheats in school and at play; he has been involved in several thefts, and is a persistent truant.

____ 31. Jerry does perfectly good work as long as he is left alone; he becomes extremely tense and anxious, however, whenever an adult speaks to him.

____ 32. Seven year old Virginia rubs and blinks her eyes occasionally when reading, and seems to find it difficult to distinguish between certain letters of the alphabet.

____ 33. Andy hears most, but not everything, that is said in class even though he wears a hearing aid.

____ 34. Stan's walk is a slow shuffle; he gets along on level surfaces or moderate inclines quite well, but is unable to manage stairs at all.

____ 35. Roy has a bright purple birthmark which covers one cheek and the side of his neck.

____ 36. Several times a day Lester says he can smell bananas; usually this means that he will soon fall to the floor in a convulsion which may last for several minutes.

____ 37. Carla is a persistent talker, whisperer, and notepasser.

____ 38. Bert could play songs with one finger on the piano when he was four; now, in first grade, he has begun composing little melodies to which he gives names like "Rainy Day," "Bert's Bike," or Juice-Time."

____ 39. June's eyes are crossed but she has adequate vision in either eye despite the muscle imbalance.

____ 40. Laura's speech is laboriously slow, tortured, jerky and indistinct; her voice is monotonous in pitch and she cannot control its intensity.

____ 41. Harry sulks, and sometimes gets quite noisy, whenever he loses the direct attention of the teacher.

Mark each item according to this code:

A. Regular classroom
B. Part-time, occasional aid
C. Full-time aid
D. Special class
E. Special school

____ 42. William can't hear anything with his left ear, but he gets along fairly well if he can sit in one row by the window, in a room on the quiet side of the building, with the class to his right.

____ 43. Ben is unable to walk and has been confined to a wheelchair; he manages this very skillfully and needs very little help.

____ 44. Les was born with a malformed left hand which is withered and misshapen up to the elbow.

____ 45. Once or twice during the year Peter has complained of a peculiar feeling in his stomach; about a minute afterwards he has lost consciousness and his body has been first rigid and then convulsed for several minutes.

____ 46. John has no difficulty on the playground or at the blackboard but he gets quite uncomfortable when he has to use his eyes at close range for any length of time.

____ 47. Hugh eventually mutilates or destroys everything that gets into his hands; his books are marked and torn, his desk ink-stained and scarred, and he has even managed to crack a blackboard panel.

____ 48. When anything happens to John the whole school knows it. A bump on the playground produces tears and wailing, an A for an exam brings on unrestrained shrieks of delight.

____ 49. Sam moves about somewhat awkwardly and his limbs are in a slight but continual tremor that becomes pronounced only when he is nervous or excited.

____ 50. Arnold is an extremely bright nine-year-old who is far ahead of the rest of the class in most subjects; he spends a good deal of his time working on a mathematical system he calls "kinestatics."

____ 51. Bill has difficulty in starting to talk, grimaces and strains, and repeats sounds of about half the words he says in class.

____ 52. Kate weighs enough for two children her age; it is almost impossible for her to squeeze into the standard desk.

____ 53. Helen's right hand may sometimes begin to tremble uncontrollably; during the next few minutes the spasmodic movement spreads along her arm, shoulder, and head before it finally stops.

Mark each item according to this code:

A. Regular classroom
B. Part-time, occasional aid
C. Full-time aid
D. Special class
E. Special school

____ 54. John is constantly in motion - tapping his feet, opening and closing his desk top, and shuffling papers.

____ 55. Debby cannot use bathroom facilties unless someone is there to help her; she is perfectly capable of making her needs known in ample time to avoid accidents.

PART III

On the following pages, you will find a number of statements concerning the education of exceptional children. Please indicate, by circling the appropriate number, the extent of your agreement with the statement.

1. The Regular class teacher does not have sufficient preparation time to plan individualized instruction for mainstreamed special education students in his/her classes.

Strongly Disagree	Disagree	Agree	Strongly Agree
1	2	3	4

2. Regular classroom teachers are willing to accept special education pupils into their classes.

1	2	3	4

3. General and Special Education teachers talk informally about special education problems.

1	2	3	4

4. Children placed in self-contained special education classes are more likely to be seen as different than if permitted to stay in regular classes.

1	2	3	4

5. If time were available to consult with special education personnel, regular classroom teachers would take advantage of this opportunity.

1	2	3	4

6. Special self-contained classes provide adequate educational services for the mildly handicapped and do not need to be changed.

1	2	3	4

7. It is an imposition to expect regular classroom teachers to help special education students.

1	2	3	4

8. Being placed in a special education self-contained classroom limits a student's chances for full participation in activities such as service organizations, clubs, sports, etc., normally available to regular classroom students.

1	2	3	4

9. The regular classroom teacher has the skills to help special education students.

1	2	3	4

10. The regular classroom teacher is willing to have special education personnel assist in the regular classroom.

1 2 3 4

11. The advantages of placement in self-contained special education classrooms outweigh the disadvantages of such placement for most pupils in need of special educational services.

1 2 3 4

12. A child is socially isolated from his peers when placed in a self-contained special education class.

1 2 3 4

13. Current government policy, as expressed in the Plan d'Action, imposes unreasonable demands and expectations on general education.

1 2 3 4

14. Special education services ranging from residential care to free flow service must be available within the community.

1 2 3 4

15. General educators must become more knowledgeable about exceptional children.

1 2 3 4

16. Special education practices have been free of socio-economic and ethnic discrimination.

1 2 3 4

17. While regular classroom teachers can often provide appropriate learning activities for learning disabled students, they cannot provide the emotional support these pupils need.

1 2 3 4

18. If given a chance, special education students would participate in most school activities.

1 2 3 4

19. As a result of the current emphasis on individualized instruction, regular class teachers are able to teach the exceptional child.

1 2 3 4

20. I strongly recommend the use of resource rooms for mildly handicapped children.

1 2 3 4

PART IV

The following is a survey of knowledge of remedial programs, techniques, and diagnostic procedures. Please choose the answer you consider to be the best one available.

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1. The WISC-R is designed

   a. to test infants of 4 - 6-½ years of age
   b. to test the intelligence of children of the ages 6-16 years
   c. to measure intelligence of subjects 15 years or older
   d. to measure the intelligence of a subject of any age

2. The range of intelligence generally classified by most authorities as "normal" or "average" includes persons having I.Q.'s which are:

   a. about 100
   b. in the 95-105 range
   c. 90-110 range
   d. in the 80-120 range

3. What do the Slingerland tests measure?

   a. academic ability
   b. adademic achievement
   c. specific language disabilities
   d. psycholinguistic ability

4. Which of the following questions must the teacher ask when a child is having spelling difficulty?

   a. Does the child have sufficient mental ability to learn to spell at the expected rate?
   b. Are hearing, vision and speech adequate?
   c. What specific areas of weakness in spelling does the child have?
   d. All of the above

5. Accuracy checks in oral reading tests can reveal any of the following errors except:

   a. reversals
   b. reafressions
   c. misinterpretations
   d. inversions

6. Diagnostic tests are:

   a. well suited for classifying children on the basis of intelligence
   b. usually age scales
   c. used to assess performance in specific ability or skill areas
   d. tests of differences in cognitive style

7. A WISC performance IQ which is ten to thirty points higher than the person's verbal IQ suggests:

   a. that the person has visual-perceptual problems
   b. the person may have a learning disability which probably involves difficulty in verbal expression.
   c. that the person is probably mentally handicapped
   d. none of the above

8. Who can administer the Slingerland tests?

   a. psychologists
   b. learning disability specialists
   c. classroom teachers
   d. all of the above

9. The analysis of a student's performance in a skill area indicates:

   a. the student's ability level
   b. the student's grade level in reading, math, or spelling
   c. how rapidly the child learns
   d. how the student is handling the tasks involved in the area where his performance level is low.

10. The children referred to special education services usually attract the attention of the classroom teacher and are referred for psychoeducational diagnosis due to:

   a. underachievement alone
   b. academic failure coupled with a discipline problem
   c. perceptual problems alone
   d. cultural deprivation

11. Teaching "through strength to weakness" means teaching a child who has a difficulty in visual skills primarily,

   a. via visual methods and materials only
   b. via visual methods and materials first
   c. via auditory methods and materials only
   d. via auditory methods and materials first

12. Faulty work habits which are characteristic of the performance of learning diaabled children include:

   a. working too fast and confusion of directions
   b. resentment when corrected
   c. lack of closure
   d. dysphasia

13. If a fourtn-grade child receives an I.Q. of 80 on a group intelligence test, his teacher should:

a. request that the child be placed in a lower grade
b. request that the child be put in a special class
c. re-measure the child's mental ability before taking any unusual action
d. be especially observant of the child and his work in the classroom

14. The use of checklists, screening devices, and word recognition tasks by classroom teachers is an example of:

a. standardized assessment
b. informal assessment
c. miscue analysis
d. a structured reading program

15. The diagnostic process begins when:

a. the child is referred
b. the psychoeducational diagnostician first sees the child
c. the child's parents give permission for the child to be evaluated
d. the child is suspected to have a problem

16. An individual educational plan includes:

a. assessment of the child
b. formulation of goals and objectives
c. descriptions of proposed interventions and evaluations
d. all of the above

17. The WRAT test does not include which of the following subtests?

a. reading comprehension
b. spelling
c. arithmetic
d. vocabulary

18. Indicate the major type of reading skill measured with the Durrell.

a. punctuation
b. syllabication
c. oral reading
d. independent

19. The subtests in the Woodcock Reading Mastery Test include:

a. spelling
b. letter identification
c. word attack
d. syllabication

20. Which of the following are NOT evaluated with the Spache?

a. frustration level
b. potential level
c. independent level
d. mastery level

21. The ages and grade levels at which the Beery-Buktenica is used include:

a. intermediate grades
b. preschool
c. early primary grades
d. all of the above

22. The Frosting is NOT recommended for use in:

a. assessing reading readiness
b. screening nursery school and kindergarten children
c. pinpointing the areas of visual-perceptual difficulty
d. measuring the severity of a child's visual-perceptual difficulty

23. The Beery-Buktenica was designed to measure:

a. visual-spatial relationships
b. visual-motor integration
c. visual-sequential memory
d. visual figure-ground discrimination

24. The skills which the Frosting measures include:

a. visual-sequential memory
b. spatial relations
c. eye movement
d. visual closure

25. The levels of diagnostic information which KeyMath yields include:

a. full-scale score
b. math quotient
c. item performance
d. applications

CLASSROOM BEHAVIOR INVENTORY
SHORT FORM, K-12
Earl S. Schaefer & May Aaronson

CHILD'S NAME _____ SEX _____

DATE _____ (year) _____ (month) _____ (day) TEACHER _____

BORN _____ (year) _____ (month) _____ (day) SCHOOL _____

AGE _____ (years) _____ (months)

INSTRUCTIONS

Please describe as accurately as possible the behavior of the child listed above by circling one of the four responses to each item. The information you provide will be most valid and useful if you follow the following instructions:

BASE YOUR RESPONSE UPON YOUR PERSONAL OBSERVATION AND EXPERIENCE

GIVE A RESPONSE TO EVERY ITEM BASED UPON YOUR BEST ESTIMATE

DO NOT HESITATE TO USE EXTREME RATINGS WHEN THEY SEEM APPROPRIATE

DESCRIBE THE CHILD AS COMPARED WITH CHILDREN OF THAT AGE GROUP

Thank you for sharing your observations of child behavior.

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PART I

	Very Much Like	Somewhat Like	Very Little Like	Not At All Like
1. Laughs and smiles easily and spontaneously in class.	4	3	2	1
2. Works earnestly at his classwork; doesn't take it lightly	4	3	2	1
3. Has a low, unsteady or uncertain voice when speaking to teacher or a group of classmates.	4	3	2	1
4. Is quickly distracted by events in or outside the classroom.	4	3	2	1
5. Tries to get even with a child with whom he is angry.	4	3	2	1
6. Awaits his turn willingly.	4	3	2	1
7. Is usually sad, solemn and serious looking.	4	3	2	1
8. Likes to express his ideas and views.	4	3	2	1
9. Sometimes pays attention; other times must be spoken to constantly.	4	3	2	1
10. Watches carefully when a teacher or a classmate is showing how to do something.	4	3	2	1
11. Gets angry quickly when others do not agree with his opinion.	4	3	2	1
12. Does not wait for others to approach him, but seeks out others.	4	3	2	1
13. Tries not to do or say anything which would hurt others.	4	3	2	1
14. Often cannot answer a question because his mind has wandered.	4	3	2	1
15. Gives the other an opportunity to express his point of view.	4	3	2	1
16. Ridicules and mocks others without regard for their feelings.	4	3	2	1
17. Tends to withdraw and isolate himself, even when he is supposed to be working with a group.	4	3	2	1
18. Sticks with a job until it's finished, even if it is difficult for him.	4	3	2	1

PART II

ADJUSTMENT

Circle one of the following numbers which best describes the child's general level of adjustment:

1. Well adjusted: Is well adjusted in his relationship with others and in his activities.

2. No significant problems: Gets along reasonably well; has little difficulty adjusting to others or in his activities.

3. Has problems: Has moderate difficulty getting on; is not making a good admustment to others or in his activities.

4. Has serious problems: Has serious problems of adjustment to others and in his activities; may need clinical help.

PEER RELATIONSHIPS

Circle one of the following numbers which best describes the child's relationships with his classmates:

1. Exceptionally good relationships with peers.

2. High acceptance among peers.

3. Moderate acceptance among peers.

4. No clear evidence of acceptance or rejection by peers.

5. Borderline rejection by peers.

6. Rejected generally by peers.

7. Rejected entirely by peers.

CHILDREN'S SELF CONCEPT SCALE

Name of Student:_____ Date of Testing:___ ___ ___
yr. mo. day

Sex: Male Female

School:_____ Age of Testing:___ ___
yr. mo.

Teacher:_____ Examiner:_____

General Instructions for Administration:

Individual administration:

Before administering the scale the examiner should explain to the student that sometimes it is important to find out how students really feel about themselves in order to help them.

It should be stressed that:

1. this is not a test, are that there are no right or wrong answers.
2. that results will not affect school grades.
3. they will be kept confidential.

Items should be read aloud to individual students, with the examiner circling the child's response in the booklet.

Students should be encouraged to respond to all items. If a student seems reluctant to respond to an item, continue the test, but go back to that item at the end of the test.

Some words may be difficult for younger children, or children operating in a second language, and may be defined by the examiner. It is also permissable to answer one or two questions at the beginning, particularily with reference to the all-or-none quality of the items. It should be explained that everyone feels differently at different times in different situations, but that they should respond in terms of what they generally feel.

The first seven items are designed to relax the student, as well as demonstrate the response procedure.

CHILDREN'S SELF CONCEPT SCALE

1. I hope the Expos win the World Series. . . . . yes no
2. I like Apples. (ice-cream). . . . . yes no
3. I like summer the best. . . . . yes no
4. I can swim very well . . . . . yes no
5. I am afraid of dogs. . . . . yes no
6. I like wearing new shoes. . . . . yes no
7. Arithmetic is my favorite subject. . . . . yes no
8. I am a happy person. . . . . yes no
9. It is hard for me to make friends. . . . . yes no
10. I am often sad . . . . . yes no
11. I am smart . . . . . yes no
12. I am shy . . . . . yes no
13. My classmates make fun of me . . . . . yes no
14. I get nervous when the teacher asks me a question. . . . . yes no
15. When I grow up, I will be an important person. . . . . yes no
16. I get worried when we have tests in school . . . . . yes no
17. I am well behaved in school. . . . . yes no
18. It is usually my fault when something goes wrong . . . . . yes no
19. I cause trouble to my family . . . . . yes no
20. I have good ideas. . . . . yes no
21. I am an important member of my family. . . . . yes no
22. I am good at making things with my hands . . . . . yes no
23. I give up easily . . . . . yes no

CHILDREN'S SELF CONCEPT SCALE

24. I am good in my school work . . . . . yes no
25. I do many bad things. . . . . yes no
26. I can draw well . . . . . yes no
27. I am good in music. . . . . yes no
28. I behave badly at home. . . . . yes no
29. I am slow in finishing my school work . . . . . yes no
30. I am an important member of my class. . . . . yes no
31. I am nervous. . . . . yes no
32. I can give a good report in front of the class. . . . . yes no
33. In school I am a dreamer. . . . . yes no
34. My friends like my ideas. . . . . yes no
35. I often get into trouble. . . . . yes no
36. I am obedient at home . . . . . yes no
37. I am lucky. . . . . yes no
38. I worry a lot . . . . . yes no
39. I like being the way I am . . . . . yes no
40. I feel left out of things . . . . . yes no
41. I wish I were different . . . . . yes no
42. I sleep well at night . . . . . yes no
43. I hate school . . . . . yes no
44. I am among the last to be chosen for games. . . . . yes no
45. I am sick a lot . . . . . yes no
46. I am often mean to other people . . . . . yes no

McGILL UNIVERSITY, FACULTY OF EDUCATION — OFFICE OF RESEARCH IN EDUCATIONAL POLICY

CHILDREN'S SELF CONCEPT SCALE

47. My classmates in school think I have good ideas. . . . . yes no
48. I am unhappy . . . . . yes no
49. I have many friends. . . . . yes no
50. I am cheerful. . . . . yes no
51. I am dumb about most things. . . . . yes no
52. I get into a lot of fights . . . . . yes no
53. People pick on me. . . . . yes no
54. When I try to make something, everything seems to go wrong. . yes no
55. I am picked on at home . . . . . yes no
56. In games and sports, I watch instead of play . . . . . yes no
57. I forget what I learn. . . . . yes no
58. I am easy to get along with. . . . . yes no
59. I lose my temper easily. . . . . yes no
60. I am a good reader . . . . . yes no
61. I would rather work alone than with a group. . . . . yes no
62. I am often afraid. . . . . yes no
63. I am always dropping or breaking things. . . . . yes no
64. I can be trusted . . . . . yes no
65. I am different from other people . . . . . yes no
66. I think bad thoughts . . . . . yes no
67. I cry easily . . . . . yes no
68. I am a good person . . . . . yes no

McGILL UNIVERSITY, FACULTY OF EDUCATION, OFFICE OF RESEARCH IN EDUCATIONAL POLICY

PERCEPTIONS OF THE MOBILE LEARNING CLINIC

On the following pages you will find a number of statements concerning the Mobile Clinic Project. Please indicate, by circling the appropriate number, the extent of your agreement with the statement.

Were you:

a Host Teacher _____

a Clinic Teacher _____

an Administrator of a Host school _____

of a Sending School _____

PERCEPTIONS OF THE MOBILE LEARNING CLINIC

1. Having the Clinic in this school was a worthwhile experience.

Strongly Disagree	Disagree	Agree	Strongly Agree
1	2	3	4

2. Discussions between the Clinic personnel and the Host School personnel were very helpful in understanding the child and his/her problems.

1	2	3	4

3. The Host Teachers will be able to benefit from the information given to them in the Clinic report.

1	2	3	4

4. Special Education teachers had sufficient opportunity to interact with the Clinic personnel.

1	2	3	4

5. Clinic personnel were available when you wanted to talk to them.

1	2	3	4

6. Parents were pleased with the Clinic experience for their child.

1	2	3	4

7. Host Teachers had sufficient opportunity to interact with the Clinic Teachers.

1	2	3	4

8. The Clinic hours were too long.

1	2	3	4

9. Host Teachers were pleased with the Clinic experience for the child.

1	2	3	4

10. There was sufficient opportunity for interaction between the Clinic Teacher and the parents.

1	2	3	4

.../2

11. The Clinic should be in the Host School for longer than three weeks.

Strongly Disagree	Disagree	Agree	Strongly Agree
1	2	3	4

12. Reports from the Clinic were easy to understand.

1 2 3 4

13. The Clinic emphasized reading as much as it should.

1 2 3 4

14. Interactions between the Host Teachers and the Clinic Teachers were positive.

1 2 3 4

15. The Clinic emphasized mathematics as much as it should.

1 2 3 4

16. The Clinic met the needs of the children who attended.

1 2 3 4

17. There was sufficient opportunity for interaction between the Clinic Teacher and the Host Teachers.

1 2 3 4

18. The Clinic was a good experience for the teachers who participated.

1 2 3 4

19. Host teachers have been able to implement the recommendations of the Clinic in their classrooms.

1 2 3 4

20. Host teachers have received some very useful, practical advice about the child.

1 2 3 4

21. There was adequate time to fulfil all the goals of the Clinic.

1 2 3 4

22. The Clinic program emphasized social/behavioral aspects as much as it should.

Strongly Disagree	Disagree	Agree	Strongly Agree
1	2	3	4

23. The benefits of the Mobile Clinic far outweigh any difficulties of implementation.

1	2	3	4

24. The school board should offer the Mobile Clinic program again next year.

1	2	3	4

25. Students who attended the Clinic had problems similar to those of children in the regular classroom.

1	2	3	4

PERCEPTIONS OF CLINIC TEACHERS

On the following pages you will find a number of statements concerning the Mobile Clinic Project. Please indicate, by circling the appropriate number, the extent of your agreement with the statement.

PERCEPTIONS OF CLINIC TEACHERS

1. I received support from my school for my participation in the Mobile Clinic Project.

Strongly Disagree	Disagree	Agree	Strongly Agree
1	2	3	4

2. Other teachers in the Clinic shared many of my concerns.

1	2	3	4

3. I received adequate information about the Mobile Clinic Project before leaving my class.

1	2	3	4

4. The substitute teacher who took over my class was adequately prepared to do so.

1	2	3	4

5. I had sufficient time to brief the substitute teacher about the children's work.

1	2	3	4

6. It was easy to prepare the children for my absence.

1	2	3	4

7. The children had not been negatively affected by my absence.

1	2	3	4

8. The children's work did not suffer as a result of my absence.

1	2	3	4

9. Parents did not object to having a substitute teacher in my class for three weeks.

1	2	3	4

10. Clinic participation was not overly demanding.

Strongly Disagree	Disagree	Agree	Strongly Agree
1	2	3	4

11. What I have learned is applicable to my own class teaching.

1	2	3	4

12. Parents supported my absence for the three week period.

1	2	3	4

1. Were your expectations for the Clinic met? How did they differ from what you expected?

2. What did you gain from the Clinic experience?

LAURENVAL MOBILE CLINIC PROJECT

Please identify five (5) aspects of your experience with the Mobile Clinic which you found the most valuable:

1.

2.

3.

4.

5.

Please identify five (5) aspects of your experience with the Mobile Clinic Project which you liked least:

1.

2.

3.

4.

5.

PERCEPTIONS OF THE MOBILE CLINIC

Some time has past since you were involved in the Laurenval Mobile Clinic, and we would like to have your views concerning the advantages and disadvantages of the project.

Please indicate your role in the Clinic:

Were you a:

_____ Host Principal of a Host school

_____ Vice-Principal of a Host school

_____ Principal of a sending school

_____ Vice-Principal of a sending school

_____ Both a Host and a Sending Principal

_____ Clinic Teacher

In which Clinic did you participate?

____ Souvenir

____ Twin Oaks

____ Crestview

____ McCaig

LAURENVAL MOBILE CLINIC PROJECT

Please identify five (5) aspects of your experience with the Mobile Clinic which you found the most valuable:

1.

2.

3.

4.

5.

Please identify five (5) aspects of your experience with the Mobile Clinic Project which you liked least:

1.

2.

3.

4.

5.

APPENDIX F - ETHICAL RESEARCH STATEMENT
AND APPROVAL DOCUMENTS

Appendix F

McGill University

Faculty of Graduate Studies and Research
Dawson Hall

CERTIFICATION OF ETHICAL ACCEPTABILITY FOR RESEARCH INVOLVING HUMAN SUBJECTS

A review committee consisting of:

Name	Field of Research
John Wolfall	Secondary Education
Winifred Cutler	Education + Policy Studies
Magdeleine F. Bureau	Educational Psy
[illegible]	Curriculum
L. Dumont	Counselling

has examined the application for funds in support of a project titled:

Laurenval Mobile Learning Clinic

As proposed by Jeff Derevensky, Lois Tetrault, ~~Janyne Rahming~~ (Applicant) to Ministry of Education - Pilot Project Funds (Granting agency, if any)

and consider the experimental procedures, as outlined by the applicant, to be acceptable on ethical grounds for research involving human subjects.

December 3, 1980. — Date

David C. Smith — Director of Graduate Studies in Education

Ethical review committees are to be convened by the Head of the Department, or Administrative Unit, in which the proposed research is to be done and are to consist of a representative appointed by the Dean, two individuals knowledgeable in the field of the proposed research but not associated with the proposed project and preferably not from the department in which the project is to be carried out, and one or more individuals who would represent a general point of view. The applicant should not serve on the Committee nor should he sign on behalf of the department or the faculty.

Postal address: 853 Sherbrooke Street West, Montreal, P.Q. Canada H3A 2T5

Research Committee of the Faculty of Education

Ethical Research Statement

Name of researcher OREP - Jeff Derevensky, Lois Tetreault, Janyne Rahming.

Title of research proposal Laurenval Mobile Learning Clinic

(Grant agency applied to, if any) Ministry of Education - Pilot Project Funds

1. In your research plans, how do you intend to ensure that informed consent is obtained from subjects? (Informed consent requires that subjects fully understand the nature, procedures, risks and benefits of the research and freely agree to participate in the study.)

   The Laurenval School Board has accepted and approved the research proposal and design. A research-assistant will explain the purpose of the questionnaire. Respondents will read and sign a tear-off sheet which appears on the front sheet of the questionnaire (see attached sample). Written consent has been obtained from parents of children involved in the project.

2. Are there any physical or psychological risks to subjects? If so, please explain the nature of these risks and indicate how and to what extent you intend to inform subjects of these risks.

   There are no anticipated risks to students or teachers. The project involves in-service teacher training with extra remediation provided to students.

3. Will the proposed research impinge on the subjects' right to privacy? If so, describe how you intend to inform subjects of their right to privacy and indicate what steps will be taken to protect this right.

   All responses, both teachers', students', and also administrators', will be anonymous. Individual responses will be available only to those responsible for data analysis.

4. What provisions will be made to ensure that the identity of subjects and the information obtained will be kept in confidence?

   Code numbers will be assigned to each respondent, and only group results will be analysed.

N.B. KINDLY ATTACH A ONE-PAGE SUMMARY OF YOUR RESEARCH AND RESEARCH PROCEDURES.

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